MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15912

15911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
MYRTLE	F.	ALBRIGHT	11	18	70	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN.
FEMALE	WHITE	AUGUST 20, 1894	76 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
MD.	U.S.A.		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
FROSTBURG	MINERS HOSPITAL	HOUSEWIFE	OWN HOME

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	FROSTBURG	YES [X] NO [ ]	79 MESHACH FROST VILLAGE

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
THOMAS		FATKIN	ANNA		MC FARLAND

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address	
NO	214-05-9953B	J. MARSHALL ALBRIGHT,	79 FROST VILLAGE FROSTBURG, MD. 21532

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	MYOCARDIAL INFARCTION	
DUE TO, OR AS A CONSEQUENCE OF (b)	HYPERTENSION	
DUE TO, OR AS A CONSEQUENCE OF (c)	DIABETES MELLITUS	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			N/A

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) ~~(this hospital)~~ attended the deceased from 11-3-, 1970, to 11-18, 1970, that (I) ~~(we)~~ last saw the deceased alive on 11-18 1970 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]	22c. DATE SIGNED
B. Matthew Kaufman M.D.	M.D.				11-20-70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
MATTHEW KAUFMAN, M.D.	924 SETON DRIVE, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	11-21-70	VALE SUMMIT CEMETERY	VALE SUMMIT, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST SR. FROSTBURG, MD.	NOV 27 1970	Vernon R. Randall

VR A15 (4) 45M - 1-69

1

15913

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15942

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
ALTA	M.	ANDERSON	11	07	70	12:15 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HR: HOURS / MIN
FEMALE	WHITE	08-10-99	71 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of wark done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	NONE	NONE

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND		638 FAYETTE ST.,

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
WILLIAM	Z.	MAC DONALD	SENA ~~PENNA~~	H.	HASLACKER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give wor or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT a Address
NO	218-24-8217	HOSPITAL REC., 900 SETON DR., CUMB.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4109 IMMEDIATE CAUSE (a) Acute Myocardial Infarct — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 30 min
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Previous Infarction, Chronic Congestive Heart failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			Yes

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** thot (I) (this haspital) attended the deceased from _____, 19____, ta _____, 19____, thot (I) (we) last sow the deceased alive an _____ 19____, and that in (my) (our) apinion death occurred on the date and hour ond from the couses stated above, (I) (we) (did) (did nat) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
V. Eugene Mazzocco M.D.	M.D.	☒	☐	☐	11-9-70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
V. EUGENE MAZZOCCO, M.D.	912 SETON DR., CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/10/70	Sunset Memorial Park	Cumberland Allegany Maryland

24. FUNERAL DIRECTOR - Merritt	ADDRESS 21502	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
SILCOX FUNERAL HOME. Cumberland, Md		NOV 12 1970	Vernon B. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15944 15943

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print) First: LULU	Middle: M.	Last: ARNOLD	2a. DATE OF DEATH: 11 Month 14 Day 70 Year
2b. HOUR: 3:45 AM			
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 8-19-88	6. AGE (In years last birthday): 82 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY CT. Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): HouseKeeper -At Home	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 823 MT. ROYAL AVE.			
14. FATHER'S NAME First: LOUIS	Middle: W.	Last: MILLER	15. MOTHER'S MAIDEN NAME First: MARY Middle: Last: Miller
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-07-1261	17. INFORMANT: MEMORIAL HOSPITAL	Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident
DUE TO, OR AS A CONSEQUENCE OF
(b): Hypertensive Arteriosclerotic CVD
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 Days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from 11-1, 1970, to 11-14, 1970, that (I) (we) last saw the deceased alive on 11-14 1970, and that in (my) (aur) apinian death accurred on the date and hour ond from the causes stoted above, (I) (we) (did) (did nat) view the body after death.

22b. SIGNATURE: Wilbur P James MD DEGREE	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 11/16/70	
22d. PHYSICIAN'S NAME (Type): DR. W. P. JAMES	22e. ADDRESS: 441 N. CENTRE ST. CUMBERLAND, MD.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 11/17/70	23c. NAME OF CEMETERY OR CREMATORY: St. Luke's Cemetery	23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland
24. FUNERAL DIRECTOR: Silcox-Merritt Funeral Service.	ADDRESS: Cumberland, Md 21502	25a. REC'D BY REGISTRAR DATE: NOV 17 1970	25b. REGISTRAR'S SIGNATURE: Vernon B Randall

VR A15 (4) 25m-1-70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15915 (15944)

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
MAY	E.	BARNES	11 24 70	9:35 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	WHITE	6-9-90	80 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
MARYLAND	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	HOUSEWIFE	OWN HOME

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND		228 PEAR ST.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
CHRISTOPHER	G.	HERPICK	ELIZABETH		RICE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	NONE	MEMORIAL HOSPITAL	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Thrombosis

DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c)

4339

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS DR CONTRIBUTING [ ] UNDERLYING CAUSE OF DEATH [ ] (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
			Cumberland	Allegany	

22a. I certify that (I) (this hospital) attended the deceased from 11/15/70, 19____, to 11/24/70, 19____, that (I) (we) last saw the deceased alive on 11/24/70 19____, and that in (my) (our) opinion death occurred an the date and hour and from the couses stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED
R. J. Williams M.D.		11/24/70

22d. PHYSICIAN NAME (Type)	22e. ADDRESS
DR. R. J. WILLIAMS	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Nov. 27, 1970	ROSE HILL CEMETERY	Cumberland Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Byron Kight	Cumberland, Md.	DEC 3 1970	Vernon R. Randall

VR A15 (4) 25m 7/70

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

15916

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
BABY	BOY	Barton	11 16 70	4:50 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Male	White	11-15-70	YRS.		36 / 26

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	USA	NEVER MARRIED [X]	Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Sacred Heart Hospital		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	Westernport	YES [ ] NO [X]	Rt. 1 Box 116

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Herbert		Barton, Jr.	Aleita	Kay	Diehl

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO		HOSP. RECORD-900 SETON DRIVE, CUMB., MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) HYALINE MEMBRANE DISEASE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

7761

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) PREMATURITY

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 10-15 19 70, to 10-16, 19 70, that (I) (we) last saw the deceased alive on 10-16 19 70, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Gary A. Fleming, M.D.	M.D.	[X]	[ ]	[ ]	11-16-70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
GARY A. FLEMING, M.D.	500 GREENE ST., CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/18/70	Philos	Westernport-Allegany-Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
E. J. Boal	BOAL'S FUNERAL HOME, WESTERNPORT, MD. 21562	NOV 24 1970	Vernon R. Randall

VR A15 (4)
45M - 1/69

HYALINE MEMBRANE DISEASE

PREMATURITY

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15917

15946

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: VIRGINIA	Middle: ANNA	Last: BENNETT	2a. DATE OF DEATH Month: 11 Day: 21 Year: 70	2b. HOUR: 12:30 A M	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 12 30 21	6. AGE (In years last birthday): 48 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY CO COUNTY, Md.			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Former Cafeteria Wkr.	12b. KIND OF BUSINESS OR INDUSTRY: Celanese Fibres			
13a. USUAL RESIDENCE (Where deceased lived before admission) STATE: MARYLAND	13b. COUNTY (if institution: Residence before admission): ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 224 WALNUT PLACE		
14. FATHER'S NAME First: WALTER	Middle:	Last: SHOBER	15. MOTHER'S MAIDEN NAME First: (O'NEAL) ROSE	Middle:	Last: SHOBER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 217-10-1761	17. INFORMANT: SACRED HEART HOSPITAL, 900 SETON DRIVE,	Address: CUMB., MD. 21502			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of uterine cervix with metastases
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1807
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County Stote	

22a. I certify that (I) (this hospital) attended the deceased from 11/9, 19 70, to 11/21, 19 70, that (I) (we) last saw the deceased alive on 11/20 19 70, and that in (my) (our) opinion death occurred on the date and hour and from the couses stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Andrew Stasko M.D.	DEGREE	ATTENDING PHYS. [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]	22c. DATE SIGNED: 11-21-70
22d. PHYSICIAN'S NAME (Type): A. STASKO, M.D.	22e. ADDRESS: 401 DECATUR STREET, CUMB., MD. 21502				

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 11/23/70	23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park,	23d. LOCATION (City or Town): Cumberland,	(County): Allegany (State): Md.
24. FUNERAL DIRECTOR: H. Wayne George ADDRESS: GEORGE FUNERALHOME, 202 GREENE ST., CUMB., MD.	25a. RECD BY REGISTRAR DATE: NOV 24 1970	25b. REGISTRAR'S SIGNATURE: Vernon G. Randall		

VR A15 (4)
45M - 1/69

15317

15918

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15947 A

1. DECEASED-NAME (Type or print): First TRICIA; Middle LYNN; Last BERGDOLL (BABY GIRL)
2a. DATE OF DEATH: Month 11; Day 18; Year 70
2b. HOUR: 1:37 M
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH: 11-18-70
6. AGE (In years last birthday): YRS. — IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN. 39
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE: W.VA.
13b. COUNTY
13c. CITY OR TOWN: MOOREFIELD
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET AND NUMBER: ROUTE 220
14. FATHER'S NAME First RAY; Middle B; Last BERGDOLL
15. MOTHER'S MAIDEN NAME First LINDA; Middle LEE; Last SHERMAN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes give war or dates of service)
16b. SOCIAL SECURITY NO.
17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity.
DUE TO, OR AS A CONSEQUENCE OF (b): 5½ month gestation
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 777X
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 39 minutes

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from Nov 18, 1970, to Nov 18, 1970, that (I) (we) last saw the deceased alive on Nov 18 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John A Topper MD
DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 11-19-70
22d. PHYSICIAN'S NAME (Type): DR. JOHN TOPPER
22e. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 11/21/1970
23c. NAME OF CEMETERY OR CREMATORY: Bigdoll Cemetery
23d. LOCATION (City or Town) (County) (State): Moorefield, Hardy WVa
24. FUNERAL DIRECTOR ADDRESS: Geo. K. Chambers, Moorefield, WVa
25a. REC'D BY REGISTRAR DATE: NOV 25 1970
25b. REGISTRAR'S SIGNATURE: Vernon C. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15919

CERTIFICATE OF DEATH

15948

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
MARGARET	E.	BEVANS	11	21	70	3:00 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
FEMALE	WHITE	12 10 89	80 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. COUNTY OF DEATH
WEST VIRGINIA	U.S.A.		ALLEGANY COUNTY, Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	NONE	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	MT. SAVAGE	YES ☐ NO ☐	MT. SAVAGE, MD. 21545

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
FRANCIS		HUGHES	(KILDUFF) MARY	E.	HUGHES

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	214-05-5856	SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Left Heart Failure	7 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Art. CVD	20 yrs ?!
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4124

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Carcinoma of Left Breast

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
NONE		YES ☐ NO ☒	✓

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 11-13, 1970, to 11-21, 1970, that (I) (we) last saw the deceased alive on 11-20 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
M.M. Rothstein		☒	☐	☐	11-21-70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
M.M. ROTHSTEIN, M.D.	48 BROADWAY, FROSTBURG, MD. 21532

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	11-23-70	ST. PATRICKS CEMETERY	MT. SAVAGE, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
DURST FUNERAL HOME, 57 FROST AVE., FROST., MD.	NOV 27 1970	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 14
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15920 15949

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: GLADYS	Middle: M.	Last: BLOSS	2a. DATE OF DEATH Month: 11	Day: 27	Year: 70	2b. HOUR: 10:55 P
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: AUGUST 25, 1900	6. AGE (In years last birthday): 70 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.				
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEG.	13c. CITY OR TOWN: OLDTOWN	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: ROUTE 1			
14. FATHER'S NAME First: JOHN	Middle: H.	Last: KARNS	15. MOTHER'S MAIDEN NAME First: ISABELLE	Middle:	Last: WELCH		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.					

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner) UNDERLYING [ ] CAUSE OF DEATH [ ]	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I **certify** that (I) (this hospital) attended the deceased from [illegible], 19[illegible], to 11/27, 19[illegible], that (I) (we) last saw the deceased alive on 11/27, 19[illegible], and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE [signature] DEGREE ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] 22c. DATE SIGNED 11/30/70

22d. PHYSICIAN'S NAME (Type) DR. BLANE SCHINDLER-PA 22e. ADDRESS 43 GREEN ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Nov. 30, 1970	Davis Memorial Cemetery	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	DEC 2 1970	Vernon R. Randall

VR A15 (a) 25m-1/70

1

15921

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First	Middle	Last	2a. DATE OF DEATH	2b. HOUR
	CHARLES	G.	BRADLEY	11 Month 30 Day 70 Year	9:40 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
MALE	WHITE	10-09-93	77 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
PENNA.	UNITED STATES	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY, Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during mast af warking life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND,	SACRED HEART HOSPITAL	Retired Grocer	Grocery

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	GARRETT	GRANTSVILLE	YES [X] NO [ ]	P.O. BOX 211

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
WILLIAM		BRADLEY	Jeanette ELIZABETH		BRADLEY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	232-01-0591	HOSPITAL CHART, 900 SETON DR. CUMBERLAND MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ruptured Aortic Aneurysm — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b) Hypertensive Heart Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 402X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Manth Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** thot (I) (this haspital) attended the deceased from 11-29, 19 70, to 11-30, 19 70, thot (I) (we) last saw the deceased alive on _____ 19___, and that in (my) (aur) opinion death accurred an the date ond hour ond from the causes stated above, (I) (we) (did) (did not) view the body ofter death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
SPIGGLE, WAYNE M.D.	912 SETON DR., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	12/3/70	Queens Point Cem.	Keyser, mineral, W.Va.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Don Newman NEWMAN FUNERAL HOME, GRANTSVILLE, MD.	DEC 7 1970	Vernon B. Randall

VR A15 (4)
45M - 1/69

2 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15922 15951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: HENRY	Middle: WEBSTER	Last: BREEDLOVE	2a. DATE OF DEATH Month: 11 Day: 26 Year: 70	2b. HOUR 2:10A M
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 11-30-86	6. AGE (In years last birthday): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): W. Va.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Custodian	12b. KIND OF BUSINESS OR INDUSTRY: Macaroni Fctry		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: Cresaptown	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: Cecil Aye.	
14. FATHER'S NAME First: ROBERT E. L.	Middle	Last: BREEDLOVE	15. MOTHER'S MAIDEN NAME First: MARY	Middle: JANE	Last: SELL
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No,	16b. SOCIAL SECURITY NO.: 234-32-1542 (If yes give war or dates of service)	17. INFORMANT: MEMORIAL HOSPITAL	Address: CUMBERLAND, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL VASCULAR ACCIDENT — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 11-21-70
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse lost. 4124
DUE TO, OR AS A CONSEQUENCE OF (b): ART. CVD — YEARS
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS (If either, notify medicol examiner) UNDERLYING CAUSE OF DEATH [ ] DR CONTRIBUTING [ ]	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify that (I) (this hospital) attended the deceased from 11-21-70, 19__, to 11-26, 19 70, that (I) (we) last saw the deceased alive on 11-25 19 70, and that in (my) (our) opinian death accurred an the date ond hour and from the causes stoted above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: T. R. Lusby — DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED: 11/26/70

22d. PHYSICIAN'S NAME (Type): DR. T. LUSBY — 22e. ADDRESS: XXXXXXXXXXXXXXXX LA VALE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 11/28/70	23c. NAME OF CEMETERY OR CREMATORY: Texas Cemetery	23d. LOCATION (City or Town) (County) (State): Horse Shoe Run, Preston W. Va.	
24. FUNERAL DIRECTOR: H. Wayne George	ADDRESS: 202 Greene St. Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: DEC 1 1970	25b. REGISTRAR'S SIGNATURE: Vernon R. Randall	

VR A15 (4) 25m-1/70

15923

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15952

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
REUBEN	B.	BROADWATER	11 07 70	12:15

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
MALE	WHITE	9-2-02	68 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	RETIRED	NONE

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	WESTERNPORT	YES [X] NO [ ]	328 SPRUCE ST

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
NELSON		BROADWATER	VIRGINIA		BROADWATER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO		214-07-4983	HOSPITAL REC.,	900 SETON DR., CITY

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b) ASCVD

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

DIABETES MELLITUS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, natify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Manth Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Nat while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this haspital) attended the deceased from 11-3, 19 70, to 11-7, 19 70, that (I) (we) last saw the deceased alive an 11-7 19 70 and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Matthew L Kaufman		[X]	[ ]	[ ]	11-7-70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
MATTHEW KAUFMAN, M.D.	924 SETON DR., CUMB., MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/10/70	Philos	Westernport-Allegany, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
BOWLES FUNERAL HOME.,	Westernport, Md.	NOV 13 1970	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the hospital ar attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carbon pagers (Pages 3 and 2 shauld be filed with the State Dept. of Health priar to burial, crematian, ar removal, and in any event, within 72 haurs after death.

VR A15 (Rev.)
45M - 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15924 — 15953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
JANE	L.	BRODE	NOV.	16	1970	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
FEMALE	WHITE	DEC. 23, 1895	74 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
PENNSYLVANIA	U.S.A.		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
FROSTBURG	49½ BROADWAY	HOUSE WIFE	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	FROSTBURG		49½ BROADWAY

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
THOMAS	W.	LEWIS	MARGARET	J.	JONES

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address	
		MRS. JOANNA PORTER,	RT. 2, BOX 165 FROSTBURG, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Myocardial infarction	Sudden
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary sclerosis	—
DUE TO, OR AS A CONSEQUENCE OF (c)	Generalized Arterio-sclerosis	—

4100 — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Hypertension

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS DR CONTRIBUTING ☐ UNDERLYING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (~~this hospital~~) attended the deceased from 6-10, 1961, to 11-16, 1970, that (I) (~~we~~) last saw the deceased alive on 11-10 1970, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
H.C. Diehl M.D.					11/18/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
H. C. DIEHL, M. D.	39 W. MAIN ST., FROSTBURG, MD. 21532

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	NOV. 19, 1970	FBG. MEMORIAL PARK	FROSTBURG, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
J. R. DURST, FROSTBURG, MD. 21532	NOV 23 1970	Vernon R. Randall

VR A15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15925

15954

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Robert	M.	Brodie	11 14 1970	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Male	White	7/9/1908	62 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
MD.	USA.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Sacred Heart Hospital	Kelly Fire Co.	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	Allegany	Cumberland	YES ☒ NO ☐	213 Washington Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Andrew		Brodie	Christina		McKinnon

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	213-09-7330	Robert Brodie JR. (SON)	La Vale, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) RESPIATORY FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

492X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) EMPHYSEMA

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

COR PULMONALE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
L. M. Glick	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	11-15-70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
L. M. Glick	912 SETON DR CUMBERLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/17/1970	MT. View Cemetery	Moscow, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
George Eichhorn Lonaconing, Md.	NOV 20 1970	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
45M - 1/69

15926

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: GLENN	Middle: I.	Last: CAMPBELL	2a. DATE OF DEATH Month: 11 Day: 3 Year: 70	2b. HOUR: 7:53 P
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: MAY 16, 1910	6. AGE (In years last birthday): 60 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): PENNA.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Research Spinning	12b. KIND OF BUSINESS OR INDUSTRY: Textile		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 1008 KENT AVENUE	
14. FATHER'S NAME First: WILLIAM	Middle	Last: CAMPBELL	15. MOTHER'S MAIDEN NAME First: MARY	Middle: (Riley)	Last: RILEY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: Yes (If yes give war or dates of service): War II	16b. SOCIAL SECURITY NO.	17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Thrombosis	Immediate
DUE TO, OR AS A CONSEQUENCE OF (b)	Arteriosclerosis	10 days
DUE TO, OR AS A CONSEQUENCE OF (c)	Coronary Artery disease	2 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State: Cumberland / Alleg / Md	

22a. **I certify** that (I) (this hospital) attended the deceased from 4/16/63, 19___, to 11/3/70, 19___, that (I) (~~we~~) lost saw ~~the~~ deceased alive on 11/3/70 19___, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 11/4/70	
22d. PHYSICIAN'S NAME (Type): DR. R. J. WILLIAMS	22e. ADDRESS: 122 S. CENTER ST.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Nov. 6, 1970	23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State): Cumberland Alleg, Md	
24. FUNERAL DIRECTOR: James F. Scarpelli	ADDRESS: Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: NOV 10 1970	25b. REGISTRAR'S SIGNATURE: Vernon R. Randall	

VR A15 (4)
45M - 1/69

15927

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15956

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Helen	May	Carner	Nov.	24	1970	7:30 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Female	White	April 8, 1908	62 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
W. Va.	USA		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	D.O.A. Memorial Hosp.	Housewife	Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	Cumberland	YES ☒ NO ☐	406 Virginia Ave.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Milton	K.	Osbourne	Florence	E.	Wharton

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no		Robert A. Carner, Cumberland, Md.-Son

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Hypertension, essential (severe)	Nov 10, 1970 / 14 days
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)	Hypertensive Heart Disease	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 402X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 11/10, 1970, to 11/24, 1970, that (I) (we) last saw the deceased alive on 11/10 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Attending MD for Dr Blaine Schindler		☑	☐	☐	Nov. 25, 1970

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
59 Greene St	Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11-27-1970	Sunset Memorial Park	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	NOV 30 1970	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after death.

VR A 16 (A)
45M 7/69

15928

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper(s). Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: ANDREW	Middle: F.	Last: CAVEY	2a. DATE OF DEATH Month: 11 Day: 19 Year: 70	2b. HOUR: 9:45 A M	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 11-30-05	6. AGE (In years last birthday): 64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): W. VA.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): MEMORIAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceosed lived; if institution: Residence before admission) STATE: W. VA.	13b. COUNTY: MINERAL	13c. CITY OR TOWN: KEYSER	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: RT. 4, BOX 415		
14. FATHER'S NAME First: HENRY	Middle	Last: CAVEY	15. MOTHER'S MAIDEN NAME First: MARY ELLEN	Middle	Last: LEE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 236-03-3822	17. INFORMANT: MEMORIAL HOSPITAL,	Address: CUMB., MD.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): RENAL-HEPATIC FAILURE

1538

Conditions, if ony, which gove rise to immediate couse (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF (b): RT. RENAL CARCINOMA WITH HEPATIC METASTASIS

DUE TO, OR AS A CONSEQUENCE OF (c): ADENOCARCINOMA OF COLON

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 YR.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [✓]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING [ ] UNDERLYING [ ] CAUSE OF DEATH (If either, notify medical exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / Stote

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Richard Schindler MD	DEGREE	ATTENDING PHYS. [✓]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]	22c. DATE SIGNED: 11-22-70
22d. PHYSICIAN'S NAME (Type): DR. RICHARD SCHINDLER		22e. ADDRESS: 69 GREEN STREET, CUMBERLAND, MD.			

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 11/22/70	23c. NAME OF CEMETERY OR CREMATORY: Philos	23d. LOCATION (City or Town) (County) (Stote): Westernport-Allegany Md.	
24. FUNERAL DIRECTOR	ADDRESS: Westernport, Md.	25a. REC'D BY REGISTRAR DATE: NOV 25 1970	25b. REGISTRAR'S SIGNATURE: Vernon R. Randall	

VRA15 (4) 25m-1/70

1

15929

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Melvin	Frank	Coffman	11	18	70	11:37 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
Male	White	04-22-91	79 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Virginia	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Sylvan Retreat	pipefitter	Railroad

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Cumberland	YES [X] NO [ ]	208 East Third Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Isaac	J.	Coffman	Mary	A.	Smoot

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO			Mrs. Ruth Lee Coffman,	Cumberland-Wife

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute renal insufficiency	approx. 8 days
DUE TO, OR AS A CONSEQUENCE OF (b)	C.V.A. with A.F.	many years
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerosis	many years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chr. Brain Syndrome

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING / CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 10-8, 1970, to 11-18, 1970, that (I) (we) last saw the deceased alive on 11-18 1970, and thot in (my) (our) opinion death occurred on the date ond haur and from the couses stoted above, (I) (we) (did) (did not) view the body ofter deoth.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
John F. Tepper	MD	[X]	[ ]	[ ]	11-19-70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
John F. Tepper MD	Memorial Hospital, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Nov.22,1970	Zion Memorial Park	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli,	Cumberland, Md.	NOV 27 1970	Vernon A. Randall

VR A15 (4)
45M - 1/69

1

15930

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15959

1. DECEASED-NAME (Type or print) First: VIRGINIA Middle: A. Lost: COLLINS	2a. DATE OF DEATH Month: 11- 11- Day: Year: 70	2b. HOUR P: 2:45 M	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 6-6-95	6. AGE (In years last birthday): 75 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): PA.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): NONE	12b. KIND OF BUSINESS OR INDUSTRY: None
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET AND NUMBER: 223 ARCH ST
14. FATHER'S NAME First: ~~XXXX~~ MC Middle: ALONIA Lost: PERRIN	15. MOTHER'S MAIDEN NAME First: MELISSA Middle: Lost: COLLINS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 177-16-5398	17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

4123

IMMEDIATE CAUSE (a) [illegible] — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: weeks

DUE TO, OR AS A CONSEQUENCE OF (b) [illegible] — years

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from June, 19 1968 to Nov 11, 19 70, that (I) (we) last saw the deceased alive on Nov 11 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 11/12/70	
22d. PHYSICIAN'S NAME (Type): DR. B. SCHINDLER PA	22e. ADDRESS: CUMBERLAND, MD.	

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Nov.14,1970	23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetery	23d. LOCATION (City or Town) (County) (State): Chaneysville, Pa.
24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: NOV 17 1970	25b. REGISTRAR'S SIGNATURE: Vernon R. Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

1

15931

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Alice	Dorothy	Combs	11	07	70	8/23 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Female	White	08/10/83	87 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	America	WIDOWED [X]	Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Frostburg	Miners	Housewife	Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
W.Va.	Mineral	Fort Ashby	YES [ ] NO [X]	None

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Addison	T.	Arndorff	Ceattta		Brill

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address	
no	234-40-3143	Mrs. Wm. Green, Cumberland, Md.	Grand-daughter

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 hrs ??

DUE TO, OR AS A CONSEQUENCE OF (b) AGED advanced — yrs.

DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus — yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this haspitol) attended the deceased from 10-24, 1970, to 11-2, 1970, thot (I) (we) last sow the deceased alive on 10-6 1970, and that in (my) (aur) apinion death occurred on the dote ond haur and from the couses stated above, (I) (we) (did) (did not) view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Marvin M. Rothstein M.D.		[X]	[ ]	[ ]	11/8/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
MARVIN M. ROTHSTEIN M.D.	48 BROADWAY - FROSTBURG - MD. 21532

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
	Nov. 10, 1970	Davis Memorial Cemetery	Cumberland, Allegany Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	NOV 13 1970	Vernon R. Randall

VR A15 (4) 45M - 1/69

1

FOR STATE HEALTH DEPT.

15932

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15961

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3) Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First: ORRIE	Middle: L.	Last: CORBETT	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month: NOV. Day: 8 Year: 1970		2b. HOUR: 6 AM
3. SEX: F	4. RACE: W	5. DATE OF BIRTH: 2-27-1884	6. AGE (In years last birthday): 86 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month: NOV. Day: 8 Year: 1970	2d. HOUR: 6:30 PM
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 350 DAVIDSON STREET	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 350 DAVIDSON STREET	
14. FATHER'S NAME First: JACOB	Middle: I.	Last: MELLOTT	15. MOTHER'S MAIDEN NAME First: NAOMA	Middle:	Last: TRUAX
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 220 52 9785	17. INFORMANT: MARY WENRICK	ADDRESS: CUMBERLAND, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

4109

IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Coronary Sclerosis — --

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]
21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ADDRESS (Street, City, town, County): R.D. 9, CUMBERLAND, MD.

22b. DATE SIGNED: NOV. 8, 1970

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: NOV. 11, 1970	23c. NAME OF CEMETERY OR CREMATORY: MT. TABOR CEMETERY	23d. LOCATION (City or Town) (County) (State): SPRING GAP, MARYLAND	
24. FUNERAL DIRECTOR: BYRON KIGHT	ADDRESS: CUMBERLAND, MD.	25a. REC'D BY REGISTRAR DATE: NOV 12 1970	25b. REGISTRAR'S SIGNATURE: Vernon G. Randall	

VR A15ME (5)
10M - 1/69

FOR STATE HEALTH DEPT.

15933

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15962

1. DECEASED-NAME (Type or Print) First: Michael	Middle: ("Mike")	Last: Costabile						2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year: Nov. 13, 1970		2b. HOUR: 12:30 PM	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: March 26, 1900	6. AGE (In years last birthday): 70 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.	2c. DATE PRONOUNCED DEAD Month Day Year: November 13, 1970		2d. HOUR: 1:30 PM	
7a. BIRTHPLACE (State or foreign country): New York	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]						9. COUNTY OF DEATH: Allegany Md.			
10. CITY OR TOWN OF DEATH: Westernport	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): 102 Spring St. Westernport, Md	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Barber	12b. KIND OF BUSINESS OR INDUSTRY: Barber								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md	13b. COUNTY: Allegany	13c. CITY OR TOWN: Westernport	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 102 Spring Street.							
14. FATHER'S NAME First: Domenick	Middle	Last: Costabile	15. MOTHER'S MAIDEN NAME First: NK	Middle	Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 213 01 9044	17. INFORMANT: Vauda Costabile	ADDRESS: Westernport, Md. 21562								

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4109
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO, OR AS A CONSEQUENCE OF
Conditians, if any, which gave rise to immediate cause (a), stating the underlying couse last.
(b): CORONARY SCLEROSIS — --
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Yeor HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Port 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At hame, farm, street, foctary, affice building, etc.)	21f. LOCATION Street ar R.F.D. Na.	City or Town	County	State

22a. **I certify** that I taak charge of the remains described abave, held an Autapsy [ ], Inspection [X], Inquiry [X] and in my apinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Benedict Skitarelic M.D. / BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
22b. DATE SIGNED: November 13, 1970
ADDRESS (Street, city, town): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/16/70	Philos Cemetery	Westernport Allegany Md.

24. FUNERAL DIRECTOR: E. L. Boal — ADDRESS: Westernport Md.

25a. REC'D BY REGISTRAR DATE: NOV 16 1970

25b. REGISTRAR'S SIGNATURE: Vernon R. Randall

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 10M - 1/69

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15934 — 15963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: EDWARD	Middle:	Last: CURRENS	2a. DATE OF DEATH: 11 Month, 20 Day, 70 Year	2b. HOUR: 2:45 PM
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 2-3-92	6. AGE (In years last birthday): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): PENNSYLANIA	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY COUNTY, Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired R.R. Employee	12b. KIND OF BUSINESS OR INDUSTRY:		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 461 WAVERLY TERRACE	
14. FATHER'S NAME First: JAMES	Middle:	Last: CURRENS	15. MOTHER'S MAIDEN NAME First: ISABELLE	Middle:	Last: POTTER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): UNKNOWN	16b. SOCIAL SECURITY NO.: 705-05-4463	17. INFORMANT: MEMORIAL HOSPITAL	Address: CUMBERLAND, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cor Art Sclr CVD x Chr Anemia

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c): Generalized

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4134

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —

21a. ACCIDENT WAS DR CONTRIBUTING [ ] UNDERLYING CAUSE OF DEATH [ ] (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY Ooccurred (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. / City or Town / County / State: Cumberland Allegany Md.

22a. I certify that (I) (~~this hospital~~) attended the deceased from 11/20/70, 19__, to 11/20/70, 19__, that (I) (we) last saw the deceased alive on 11/20/70 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: R. J. Williams M.D.

DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. DATE SIGNED: 11/21/70

22d. PHYSICIAN'S NAME (Type): DR. R.J. WILLIAMS

22e. ADDRESS: 122 S. CENTRE ST. CUMB. MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 11/23/70	23c. NAME OF CEMETERY OR CREMATORY: Fairview Christian Cemetery	23d. LOCATION (City or Town): Artemas	(County): Bedford (State): Penna
24. FUNERAL DIRECTOR: Silcox-Merritt Funeral Service.	ADDRESS: Cumberland, Md 21502	25a. REC'D BY REGISTRAR DATE: NOV 24 1970	25b. REGISTRAR'S SIGNATURE: Vernon R. Randall	

VR A15 (4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15935 — 15964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
CARL	FREDERICK	DAUPHIN	11 7 70	11:00AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In yeors last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
MALE	WHITE	2-20-95	75 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
ILLINOIS	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	MINISTER	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALEEGANY	LA VALE	YES [ ] NO [X]	105 MARY ST.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
FREDERICK		DAUPHIN	CHRISTINE		DROEGE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	215-36-8482	MEMORIAL HOSPITAL	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic carcinoma, generalized from — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma Colon — 2-3 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2yrs.	Carcinom Colon	YES [ ] NO [X]	

21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING CAUSE OF DEATH / DR CONTRIBUTING	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Yeor 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from _____, 19____, to 11-7, 19 70, that (I) (~~we~~) last saw the deceased alive on 11-7 1970, and that in (my) (~~our~~) opinian death accurred on the date and haur and from the causes stated abave, (I) (~~we~~) (did) (did nat) view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Carlton Brinsfield MD		[ ]	[ ]	[X]	11-9-70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. C. BRINSFIELD	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	11/9/70	ZION CHURCH CEMETERY	ACCIDENT, GARRETT, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE RECD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Ruth Neusner	GRANTSVILLE, MD.	NOV 13 1970	Vernon G. Randall

VR A15(M) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15936 15965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: MARY	Middle: L.	Last: DERRY	2a. DATE OF DEATH Month 11 Day 14 Year 70
2b. HOUR: 10:55 PM			
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 08-05-96	6. AGE (In years last birthday): 74 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY COUNTY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND, MARYLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: PENNSYLVANIA	13b. COUNTY: SOMERSET	13c. CITY OR TOWN: MEYERSDALE	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 227 BROADWAY			
14. FATHER'S NAME First: MARSHALL	Middle: J.	Last: LIVENGOOD	15. MOTHER'S MAIDEN NAME First: CAROLINE Middle:	Last: RAVENSCROFT
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (Unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 206-40-8985	17. INFORMANT: HOSPITAL RECORD, SACRED HEART HOSPITAL Address	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

4109 IMMEDIATE CAUSE (a) Acute Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Atherosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Atherosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Clarence L. Vincent M.D. DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐
22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type): VINCENT, CLARENCE, M.D.	22e. ADDRESS: 924 SETON DRIVE, CUMBERLAND, MD.		

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE: 11-18-70	23c. NAME OF CEMETERY OR CREMATORY: Y.O.O.F. Cem.	23d. LOCATION (City or Town): Salisbury	(County) (State): Pa.
24. FUNERAL DIRECTOR: KONHAUS FUNERAL HOME, MEYERSDALE, PA.	ADDRESS	25a. REC'D BY REGISTRAR DATE NOV 19 1970	25b. REGISTRAR'S SIGNATURE	

VR A15 (4)
45M - 1/69

15939

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15937

15966

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
CARL	L.	DIVELBISS	11 20 70	2:28 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
MALE	WHITE	03 22 07	63 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
WEST VIRGINIA	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY COUNTY, Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	RETIRED - B & O RAILROAD	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES / NO	13e. STREET AND NUMBER
PENNSYLVANIA	BEDFORD	HYNDMAN	YES [XX] NO [X]	BOX 269, HYNDMAN, PENNA. 15545

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
ELLIOTT		DIVELBISS	(GOODMAN) NORA		DIVELBISS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	7085-09-9045	SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Myocardial Infarct — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 days

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Heart Disease — 3 years

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 8-7, 1967, to 11-20 1970, that (I) (we) last saw the deceased alive on 11-19 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
R. W. Ballin M.D.		[X]	[ ]	[ ]	11-20-70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
R.W. BALLIN, M.D.	51 GREENE ST., CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Nov. 22, 1970	Hyndman Cemetery	Hyndman, Bedford Co., Pa.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
ZIEGLER FUNERAL HOME, HYNDMAN, PENNA.	NOV 25 1970	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
45M - 1/69

15937

CERTIFICATE OF DEATH

CARL L. DIVELBISS 11 20 70 2:28

MALE WHITE 03 22 07 63

WEST VIRGINIA U.S.A. ALLEGANY COUNTY,

CUMBERLAND SACRED HEART HOSPITAL RETIRED - B&O RAILROAD 15545

PENNSYLVANIA BEDFORD HYNDMAN x 8/ 80X 263, HYNDMAN, PENNA.

ELLIOTT DIVELBISS (GOODMAN) NORA DIVELBISS
MD. 21502

NO 7025-09-0045 SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,

Myocardial Infarct 2 days

Coronary Heart Disease 3 years

x

11 - 19 70 8 - 7 67 11 - 20 70

x 11-20-70

R.W. BALLIN, M.D. 51 GREENE ST., CUMBERLAND, MD.21502

Key, 2, Life Insurance Company

SIEGLER FUNERAL HOME, HYNDMAN, PENNA.

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15939

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
JOHN	WILSON	DODD	NOV. 15, 1970	1:20 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
MALE	WHITE	FEB. 4, 1906	64 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	CUMBERLAND NURSING HOME	SUPERINTENDENT	COMM. BLDG.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
PENNA	BEDFORD	BEDFORD	YES ☐ NO ☒	BOX 290, ROUTE 3,

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JONATHAN	B.	DODD	JESSIE		WHITEHAIR

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	220 28 9512	ERIS M. DODD	ROUTE 1, BEDFORD, PA.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma, metastatic, generalized — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 Mo.

DUE TO, OR AS A CONSEQUENCE OF

(b) Primary undetermined

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1990

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 ar Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospitol) ottended the deceased from Nov. 1, 1970, to Nov. 15, 1970, that (I) (we) last saw the deceased alive an Nov. 14 1970, and that in (my) (aur) opinian death occurred on the dote ond haur and from the causes stoted obave, (I) (we) (did) (did not) view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Benedict Skotarelic		☒	☐	☐	

22d. PHYSICIAN'S NAME (Type)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	NOV. 18, 1970	SUNSET MEMORIAL PARK	CUMBERLAND, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
BYRON KIGHT	CUMBERLAND, MD.	NOV 23 1970	Vernon O. Randall

VR A15 (R)
45M - 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15939 — 15968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: MARY	Middle: NMI	Last: DRABISH	2a. DATE OF DEATH: Month 11 Day 11 Year 70	2b. HOUR: 2:00 M
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 09-21-91	6. AGE (In years last birthday): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): POLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY COUNTY, Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): NONE	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: PENNSYLVANIA	13b. COUNTY	13c. CITY OR TOWN: BERLIN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: ROUTE 4	
14. FATHER'S NAME First: ANDREW	Middle	Last: SALABAI	15. MOTHER'S MAIDEN NAME First: FANNIE	Middle	Last: SALABAI
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address: HOSPITAL RECORD, 900 SETON DR., CUMBERLAND, MD. 21502		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Congestive Heart Failure	2yrs
DUE TO, OR AS A CONSEQUENCE OF (b)	Generalized Atherosclerosis	13yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4409

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hedremoid reaction ? Anemia, etiol not determined

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)		
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** that (I) (this hospital) attended the deceased from 10-31, 1920, to 11-11, 1970, that (I) (we) last saw the deceased alive on 11-11 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: WO Spiggle MD	DEGREE	ATTENDING PHYS. ☑	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED: 11-12-70
22d. PHYSICIAN'S NAME (Type): WAYNE SPIGGLE, M.D.		22e. ADDRESS: 912 SETON DR., CUMBERLAND, MD. 21502			

23a. BURIAL, ~~CREMATION~~, REMOVAL (Specify)	23b. DATE: Nov. 14, 1970	23c. NAME OF CEMETERY OR CREMATORY: Pine Hill	23d. LOCATION (City or Town) (County) (State): Buckhannon Valley Twp Somerset, Pa.	
24. FUNERAL DIRECTOR: Walter A. Johnson	ADDRESS: JOHNSON'S FUNERAL HOME, BERLIN, PA. 15530	25a. REC'D BY REGISTRAR DATE: NOV 16 1970	25b. REGISTRAR'S SIGNATURE: Vernon A. Randall	

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15940 — 15969

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: PATRICK	Middle: RYAN	Last: FARRELL	2a. DATE OF DEATH: 11 Month 14 Day 70 Year	2b. HOUR: M	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 10-14-05	6. AGE (In years last birthday): 65 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY, Md.			
10. CITY OR TOWN OF DEATH: CUMBERLAND, MD	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): XX SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RETIRED	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: MT. SAVAGE	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 101 MAC'S HILL		
14. FATHER'S NAME: LAST FARRELL FIRST JOHN MIDDLE H.	15. MOTHER'S MAIDEN NAME: First ELIZABETH Middle Last SHAFFER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 217-05-2241	17. INFORMANT Address: HOSPITAL CHART, SHH, 900 SETON DR., CUMB.MD.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Liver Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO, OR AS A CONSEQUENCE OF (b): Cirrhosis of Liver due to Chronic — 1 yr
DUE TO, OR AS A CONSEQUENCE OF (c): Hepatitis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): NONE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS OR CONTRIBUTING [ ] UNDERLYING CAUSE OF DEATH [ ] (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that (I) (this hospital) attended the deceased from 11-7, 1970, to 11-14, 1970, that (I) (we) last saw the deceased alive on 11-14 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: M.M. Rothstein	DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 11-15-70	
22d. PHYSICIAN'S NAME (Type): M.M. ROTHSTEIN, M.D.	22e. ADDRESS: 48 BROADWAY, FROSTBURG, MD.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 11/17/70	23c. NAME OF CEMETERY OR CREMATORY: St. Patricks Cem.	23d. LOCATION (City or Town): MT Savage	(County): (Allegany) (State): Md
24. FUNERAL DIRECTOR: STEIN FUNERAL HOME	ADDRESS: 117 FREDERICK ST., CUMB. MD.	25a. REC'D BY REGISTRAR DATE: NOV 18 1970	25b. REGISTRAR'S SIGNATURE: Vernon D. Randall	

VR A (5-4) 25m-1/70

PATRICK	RYAN	FARRELL		11	14	70
MALE	WHITE	10-14-05				65
MARYLAND	UNITED STATES	X				ALLEGANY,
CUMBERLAND, MD		MX SACRED HEART HOSPITAL				RETIRED
MARYLAND	ALLEGANY	MT. SAVAGE	X		101 MACK'S HILL	
LAST	FIRST	MIDDLE				
FARRELL	JOHN	H.		ELIZABETH		SHAFFER

217-05-2241 HOSPITAL CHART, SHH, 900 SETON DR., CUMB.MD.

M.M. ROTHSTEIN, M.D. 16 BROADWAY, FROSTBURG, MD.

STEIN FUNERAL HOME, 117 FREDERICK ST., CUMB. MD

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15941

15970

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Mary	Middle: E.	Last: Ford	2a. DATE OF DEATH Month: 11 Day: 4 Year: 1970
2b. HOUR: M			
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 2/19/1883	6. AGE (In years last birthday): 87 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): West Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.
10. CITY OR TOWN OF DEATH: Lonaconing	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): St. Marys Terrace	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Retired-Ladies	12b. KIND OF BUSINESS OR INDUSTRY: Apparel
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.	13b. COUNTY: Allegany	13c. CITY OR TOWN: Lonaconing	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: St. Marys Terrace
14. FATHER'S NAME First: Jerry	Middle:	Last: O,Neill	15. MOTHER'S MAIDEN NAME First: Ella	Middle:	Last:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-32-2800	17. INFORMANT: Mary Francis Devlin (NEICE)	Address: Lonaconing, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Ischemia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hrs.
DUE TO, OR AS A CONSEQUENCE OF
(b) Generalized Arteriosclerosis — years
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if ony, which gove rise to immediate cause (a), stating the underlying cause lost. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this haspital) attended the deceased from _____, 19 60, to Nov. 4, 19 70, that (I) (we) last saw the deceased alive on 10-26 1970 and that in (my) (our) apinion death occurred an the date ond hour and from the causes stated above, (I) (we) (did) (did not) view the bady after death.

22b. SIGNATURE: L.R. Miles MD DEGREE	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 11.5.70	
22d. PHYSICIAN'S NAME (Type): L.R. MILES JR. MD.	22e. ADDRESS: LONACONING MD 21539		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 11/7/1970	23c. NAME OF CEMETERY OR CREMATORY: St. Marys Cemetery	23d. LOCATION (City or Town): Lonaconing, Md.	(County) (State)
24. FUNERAL DIRECTOR: George Eichhorn	ADDRESS: Lonaconing, Md.	25a. REC'D BY REGISTRAR DATE: NOV 9 1970	25b. REGISTRAR'S SIGNATURE: Vernon B. Randall	

VR A15 (4)
45M - 1/69

1

15942

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15971

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: EVELYN	Middle: LAVERNE	Last: GALFORD	2a. DATE OF DEATH: Month 11 Day 30 Year 70 — 2b. HOUR: 2:42 AM
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 02-02-20	6. AGE (In years last birthday): 50 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN	
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY COUNTY Md.	
10. CITY OR TOWN OF DEATH: CUMBERLAND, MD.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): SACRED HEART	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 109 N. JOHNSON STREET
14. FATHER'S NAME First: ADAM	Middle: L.	Last: BITTINGER	15. MOTHER'S MAIDEN NAME First: ANNA	Middle: E. Last: DYE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 220-10-8811	17. INFORMANT: HOSPITAL RECORD, SACRED HEART HOSPITAL	Address	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 DAYS
4109
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
EMPHYSEMA, COR PULMONALE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from 9-22-55 to 11-30-70, that (I) (we) last saw the deceased alive on 11-30-70, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Ralph W. Ballin M.D. DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 11-30-70		
22d. PHYSICIAN'S NAME (Type): R. W. BALLIN, M.D.	22e. ADDRESS: 51 GREENE STREET, CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 12/3/70	23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Pk.	23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Md.
24. FUNERAL DIRECTOR: STEIN'S FUNERAL HOME, 117 FREDERICK STREET	ADDRESS: Cumb. Md.	25a. REC'D BY REGISTRAR DATE: DEC 7 1970	25b. REGISTRAR'S SIGNATURE: Vernon G. Randall

VR A15-4
45M - 1/69

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2, and 3 to the funerol director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15943

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15972

1. DECEASED-NAME (Type or Print) First	Middle	Lost
Norman	Joseph	Gellner

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month 11 Doy 30 Year 1970 — 2b. HOUR 6:02p M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN.
Male	White	June 5, 1911	59 YRS.				

2c. DATE PRONOUNCED DEAD Month November Doy 30 Year 1970 — 2d. HOUR 6:02p M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Washington, D&C	U.S.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Sacred Heart Hospital--DOA	Life Ins. Agent	Life Ins.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	LaVale	YES [ ] NO [X]	1212 LaVale Avenue

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Joseph		Gellner	Louise		Ruppert

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW II	214-05-5145	Catherine Goldsworthy Gellner	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 4109

(b) Coronary Sclerosis — ----

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Doy, Yeor HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X] and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: November 30, 1970

ADDRESS(Street, city, town, CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	12-4-70	S.S. Peter and Paul	Cumberland, Alleg. Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Philip B. Wendt	Cumb., Md. 121 Memorial Ave.	DEC 4 1970	Vernon G. Randall

VR A15ME (5) 10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15944 — 15973

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
WILLIAM	LEO	GOLDSWORTHY	11	29	70	2:20 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	WHITE	01-21-00	70 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY COUNTY, Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	GLENN L. MARTIN CO.	Aircraft

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CRESAPTOWN	YES [X] NO [ ]	218 Winchester Rd.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
PAUL		GOLDSWORTHY	(HELFRICH) ANNA		GOLDSWORTHY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	214-07-4119	HOSPITAL RECORD, 900 SETON DR., CUMBERLAND, MD 21502

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute coronary occlusion	1 day
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary sclerosis	1 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)	diabetes	10 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2509

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 4-3, 1960, to 11-29-, 1970, that (I) (we) last saw the deceased alive on 11-29- 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS	MED DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
L. Brings		[ ]	[X]	[ ]	11-29-70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
L. BRINGS, M.D.	57 GREENE ST., CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	12/2/70	SS. Peter & Paul Cem.	Cumberland, Allegany Md.

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Wayne George GEORGE FUNERAL HOME, 202 GREENE ST., CUMB., MD. 21502	DEC 3 1970	Vernon R. Randall

VR A15 45M - 1/69

19042

1

15945

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15974

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
BABY GIRL		GORDON	11	16	70	9:50 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
FEMALE	WHITE	11/16/70				5	10

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	None	None

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	MT. SAVAGE	YES ☐ NO ☐	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
			KATHLEEN		GORDON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give wor or dates of service)	17. INFORMANT Address
No	None	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) 5 mo. gestation Premature 1 lb 12 oz baby — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 hrs

DUE TO, OR AS A CONSEQUENCE OF (b) maternal hemorrhage 1 wk duration — 1 wk.

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
UNDERLYING CAUSE OF DEATH ☐ OR CONTRIBUTING ☐		

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** thot (I) (this haspitol) ottended the deceosed from 11/16/70, 19___, to 11/16/70 19___, that (I) ~~(we)~~ last sow the deceased alive on 11/16/70 19___, and that in (my) ~~(our)~~ opinion deoth occurred on the dote and hour and from the couses stated obave, (I) ~~(we)~~ ~~(did)~~ (did not) view the bady after deoth.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
R. A. Reiter M.D.		☒	☐	☐	11/17/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. RALPH A. REITER	FREDERICK ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Nov.17,1970	Gordon Family Cemetery	Mt.Savage, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	NOV 20 1970	Vernon R. Randall

VR A15(4)
25m-1-70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15947 15975

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: JAMES	Middle: WILLIAM	Last: HAGER	2a. DATE OF DEATH: Month 11 Day 21 Year 70	2b. HOUR: 7:50 AM
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 03 01 93	6. AGE (In years last birthday): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY CO., Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): RETIRED QUEEN CITY BREWERY	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 14 S. CHASE ST.	
14. FATHER'S NAME First: MARTIN	Middle: J.	Last: HAGER	15. MOTHER'S MAIDEN NAME First: (LONG) BERTHA	Middle: C.	Last: HAGER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214 05 7065	17. INFORMANT: PATIENT'S HOSPITAL CHART	Address: 900 SETON DRIVE CUMBERLAND, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinomatosis, generalized, to — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 months

DUE TO, OR AS A CONSEQUENCE OF (b): lungs & Kidneys, 1538 — 1/2 month

Conditians, if any, which gove rise to immediate couse (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c): Carcinoma of colon

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from 10, 19 69, to 11/21, 19 70, that (I) (we) last saw the deceased alive on 11/21 19 70, and that in (my) (our) opinian death accurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: H Wayne George MD for DR Beaine Schindler	DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 11/23/70	
22d. PHYSICIAN'S NAME (Type): B. SCHINDLER, M.D. T.A.	22e. ADDRESS: 43 GREENE ST., CUMBERLAND, MD. 21502		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 11/23/70	23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park,	23d. LOCATION (City or Town): Cumberland,	(County): Allegany (State): Md.
24. FUNERAL DIRECTOR: H. Wayne George	ADDRESS: GEORGE FUNERAL HOME, 202 GREENE ST., CUMBERLAND, MD.	25a. REC'D BY REGISTRAR DATE: NOV 24 1970	25b. REGISTRAR'S SIGNATURE: Vernon R. Randall	

VR A (5) (4) 45M · 1-69

1852?

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15943 15976

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1. DECEASED-NAME (Type or print) First / Middle / Last	Grace E. Hansel	2a. DATE OF DEATH Month / Day / Year	Nov. 1 1970	2b. HOUR	9:10 AM
3. SEX	Female	4. RACE	White	5. DATE OF BIRTH	5-6-83
6. AGE (In years last birthday)	87 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country)	Keyser	7b. CITIZEN OF WHAT COUNTRY?	U.S.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. COUNTY OF DEATH	Allegany Md.				
10. CITY OR TOWN OF DEATH	Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	Lions Manor Nursing Home	12a. USUAL OCCUPATION (Kind of work done during mast af warking life, even if retired.)	Housewife
12b. KIND OF BUSINESS OR INDUSTRY	Own Home				
13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE	Maryland	13b. COUNTY	Allegany	13c. CITY OR TOWN	Cumberland
13d. INSIDE CITY LIMITS?	YES ☒ NO ☐	13e. STREET AND NUMBER	Rt. # 3, Bedford Rd.		
14. FATHER'S NAME First / Middle / Last	William H. Bawden	15. MOTHER'S MAIDEN NAME First / Middle / Lost	Henrietta Parker		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	no	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address	Daughter Mrs. Henrietta Snyder, Bedford Road-Cumb.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Adenocarcenoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: approx 2yrs

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if ony, which gove rise ta immediate cause (a), stating the underlying cause lost.

(b) Adenocarcinoma ascending colon

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Manth Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 ar Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Nat while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street ar R.F.D. No. / City or Town / County / State	

22a. I certify that (I) (this hospitol) ottended the deceosed from 10-1, 1970, to 11-1, 1970, thot (I) (we) lost saw the deceased alive on 10-31 1970, and that in (my) (our) opinion deoth occurred an the date and haur and from the couses stated abave, (I) (we) (did) (did not) view the body ofter death.

22b. SIGNATURE	Wayne Spiggle M.D.	DEGREE	ATTENDING PHYS. ☐	MED. DIRECTOR ☐	STAFF PHYS. ☒
22c. DATE SIGNED	11-1-70				
22d. PHYSICIAN'S NAME (Type)	Wayne Spiggle M.D.	22e. ADDRESS	Seton Drive		

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
	Nov. 3, 1970	Sunset Memorial Park	Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
Scarpelli Funeral Home, Cumberland, Md.		NOV 5 1970	Vernon R. Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15949 — 15977

1. DECEASED-NAME (Type or print)	First: MESHACH	Middle: B.	Last: HAWN	2a. DATE OF DEATH: Month NOVEMBER Day 20, Year 1970	2b. HOUR: 5:00PM
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 01-21-95	6. AGE (In years last birthday): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED XX	9. COUNTY OF DEATH: ALLEGANY Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY: KELLY TIRE CO.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER: RT. 6, BOX 171	
14. FATHER'S NAME First: MILTON	Middle	Last: HAWN	15. MOTHER'S MAIDEN NAME First: HENRIETTA	Middle	Last: WEIMER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: YES (If yes give war or dates of service): W.W. 1	16b. SOCIAL SECURITY NO.: 214-05-9680	17. INFORMANT Address: HOSP. RECORD-900 SETON DRIVE, CUMB., MD.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart failure. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
(b): A.S.C.V.D.
DUE TO, OR AS A CONSEQUENCE OF
(c): Generalized arteriosclerosis.

4124

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Pulmonary Emphysema.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Clarence Vincent	MD		☑	☐	

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
CLARENCE VINCENT, M.D.	924 SETON DRIVE, CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	11-23-70	I.O.O.F. CEMETERY	SALISBURY, PA.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
DURST FUNERAL HOME, FROSTBURG, MD. 21532	NOV 27 1970	Vernon B. Randall

1

15950

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item#13, FilmG430 11/10/70 kam

CERTIFICATE OF DEATH

15978

1. DECEASED-NAME (Type or print)	First: Othilie	Middle:	Last: Heipp	2a. DATE OF DEATH Month: Nov	Day: 3	Year: 70	2b. HOUR: 4:50 A M
3. SEX: F	4. RACE: W	5. DATE OF BIRTH: Sep 17 1881	6. AGE (In years last birthday): 89 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): md	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.				
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Sylvan Retreat	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Teacher-Cook School	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Alleg.	13c. CITY OR TOWN: Frostburg	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET AND NUMBER: None			
14. FATHER'S NAME First: Peter	Middle:	Last: Heipp	15. MOTHER'S MAIDEN NAME First: Lizzie	Middle:	Last: Pecher		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 388-20-4656	17. INFORMANT	Address				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary thrombosis	few minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary occlusion	few days
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerosis	many years.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** that (I) (this hospital) attended the deceased from July 6, 1966, to Nov 3, 1970, that (I) (we) last saw the deceased olive on Nov 3 1970 and that in (my) (our) opinion death accurred an the date and hour ond fram the couses stated above, (I) (we) (did) (did not) view the body after deoth.

22b. SIGNATURE: John A Topper MD	DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☑	22c. DATE SIGNED: 11 3 70		
22d. PHYSICIAN'S NAME (Type): John A. Topper MD	22e. ADDRESS: Memorial Hospital Cumberland, Md.			

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Nov.5,1970	23c. NAME OF CEMETERY OR CREMATORY: Prosperity M.E.Cemetery	23d. LOCATION (City or Town) (County) (State): Beans Cove Alleg. Maryland	
24. FUNERAL DIRECTOR: James F.Scarpelli, Cumberland, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE: NOV 6 1970	25b. REGISTRAR'S SIGNATURE: Vernon R. Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M · 1/69

15951

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15979

1. DECEASED-NAME (Type or print) First	Middle	Lost	2a. DATE OF DEATH Month Day Year	2b. HOUR
BERNARD	J.	HENAGHAN	11 01 70	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
MALE	WHITE	5-17-10	60 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	UNITED STATES	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY, Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND, MD.	SACRED HEART HOSPITAL	C. FOREMAN - MD. STATE ROAD COMM.	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	FROSTBURG	YES [ ] NO [X]	RT 2, BOX 134

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
JOHN		HENAGHAN	ANNA	MARY	WILDERMAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	213-10-9105	HOSPITAL RECORD, 900 SETON DR., CUMBERLAND, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic adenocarcinoma. 1990
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if ony, which gove rise to immediate cause (a), stoting the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Generalized arteriosclerosis.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this haspital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and thot in (my) (our) opinion death occurred on the date and hour and fram the causes stated above, (I) (we) did) (did nat) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
C. J. Vincent	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
VINCENT, CLARENCE M, D.	924 SETON DR., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	11/4/70	ST. MICHAELS CEMETERY	FROSTBURG, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
DURST FUNERAL HOME, 57 FROST AVE., FROSTBURG, MD.	NOV 5 1970	Vernon B. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremotion, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremotian, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15952

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15980

1. DECEASED-NAME (Type or Print)	First: Jeannette	Middle: A.	Last: Holzshu	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐	Month: Nov.	Day: 4,	Year: 1970	2b. HOUR	6 a M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD	Month: November	Day: 4,	Year: 1970	2d. HOUR	8 a M
Female	White	2/3/1911	59 YRS.								
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH								
MD.	Usa.		Allegany Md.								
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY								
Cumberland	DOA Memorial Hospital	School Teacher									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER							
MD.	Allegany	Cumberland	YES ☒ NO ☐	203 Fayette Street							
14. FATHER'S NAME	First: Rutherford	Middle	Last: Holzshu	15. MOTHER'S MAIDEN NAME	First: Lillie	Middle	Last: Grindle				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS							
No			Esther Holzshu (Sister)	Lonaconing, Md.							

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
9500
IMMEDIATE CAUSE (a) Barbiturate Poisoning
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if ony, which gove rise to immediote couse (a), stating the underlying couse last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Yeor HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I taak charge of the remains described abave, held an Autapsy ☒, Inspection ☒, Inquiry ☒ and in my apinian death resulted from: Natural causes ☐, Accident ☐, Suicide ☒ Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: November 4, 1970

ADDRESS(Street, city, town or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/7/1970	Oak Hill Cemetery	Lonaconing, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
George Eichhorn	Lonaconing, Md.	NOV 10 1970	Vernon R. Randall

VR A15ME (5)
10M REV. 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

15953

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15981

1. DECEASED-NAME (Type or Print) First / Middle / Last	2a. DATE KNOWN OF DEATH [X] / ESTIMATED [ ] Month Day Year	2b. HOUR
WILLIAM PIERCE HUNTER, SR.	11-5-70 19	10 a M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month Day Year 19	2d. HOUR
Male	White	Aug. 11, 1911	59 YRS.			November 5, 1970	11 a M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Maryland	U.S.A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Twiggtown	Twiggtown	Farmer (Ret.)	Farm

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Montgomery	Silver Spring	YES [X] NO [ ]	2022 Hanover St.

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last
William P. Hunter	Mattie Littlefield

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Unk.	No--------	577-07-8754	Catherine Hunter, Silver Spring, Md. Same #13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

4109

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) CORONARY SCLEROSIS — ---

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: Novermber 5, 1970

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/7/70	Monocacy Cemetery	Beallsville, Mont., Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Tyson Wheeler 1331 Rkvl. Pk., Rockville, Md.	NOV 9 1970	Vernon R. Randall

VR A15ME (5) 10M REV. 1/68

2800

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

15954

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15982

1. DECEASED-NAME (Type or Print)	First: Elva	Middle: G race	Last: Johnston	2a. DATE KNOWN OF DEATH ESTIMATED ☒	Month: Nov.	Day: 30	Year: 1970
2b. HOUR	8A M						
3. SEX	Female	4. RACE	White	5. DATE OF BIRTH	Oct. 12, 1903	6. AGE (In years last birthday)	67 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.						
2c. DATE PRONOUNCED DEAD	Month: November	Day: 30,	Year: 1970				
2d. HOUR	9a M						
7a. BIRTHPLACE (State or foreign country)	Md.	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. COUNTY OF DEATH	Allegany Md.
10. CITY OR TOWN OF DEATH	Westernport	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	209 Md. Ave.	12a. USUAL OCCUPATION (Kind of work done during most of working life. If ret'd, retired.)	House Wife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Md.	13b. COUNTY	Allegany	13c. CITY OR TOWN	Westernport	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 209 Md. Ave.
14. FATHER'S NAME	First: H enry	Middle: W.	Last: Friend	15. MOTHER'S MAIDEN NAME	First: NK	Middle: NK	Last: Rexrode
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	no	(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT	Sheridan Johnston
ADDRESS	209 Md. Ave. Westernport						

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Sclerosis — ---

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Noturol causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: November 30, 1970

ADDRESS (Street, city, town or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Dec. 3, 1970	Philos Cemetery	Westernport Allegany Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
E. Lee Beal	Westernport, Md.	DEC 7 1970	Vernon G. Randall

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15955

15983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Lost	2a. DATE OF DEATH Month	Doy	Year	2b. HOUR
CARTHEN	Clair	KANE	11	27	70	4:50A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
MALE	WHITE	2-16-02	68 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
PENNSYLVANIA	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	R'Way Express Agency	Freight

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES ☒ NO ☒	Rt.#4 Box 201-A

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
John WILLIAM		KANE	LAURA	Belle	MUNDORFF

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes 1920-21	712-14-9109	MEMORIAL HOSPITAL CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac Arrest Complete Heart Block — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Massive Myocardial Infarction — days

DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular Disease — years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Carcinomoa of the Prostate

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While ☐ Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	Stote

22a. I **certify** that (I) (this haspital) attended the deceased from 1966, 19___, to Nov. 27 19 70 that (I) ~~was~~ last saw the deceased alive an 11-26-70 19___, and that in (my) (our) opinian death accurred an the date and haur and from the causes stated abave, (I) ~~(we)~~ (did) (did nat) view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
		☒	☐	☐	11-30-70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
G. OVERTON HIMMELWRIGHT M.D.	133 VIRGINIA AVE, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/30/70	Davis Memorial Cemetery	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Philip B. Wendt 121 Memorial Ave., Cumb., Md.	DEC 1 1970	Vernon G. Randall

VR A15 (4) 45M - 11-69

1

FOR STATE HEALTH DEPT.

15956

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15984

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year	2b. HOUR
Albert	Roy	Kifer	Nov. 8, 1970	4a M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Male	White	May 4, 1905	65 YRS.					November 8, 1970	5a M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Maryland	U S A		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Near Cumberland	R#9 Cumberland, Md.	Retired Trackman	W M R R

13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Flintstone	YES [ ] NO [X]	Route 1

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Silas	C	Kifer	Lottie	May	McCoy

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	203-07-1452	Mrs. Mary Kifer, Route 1, Flintstone, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bronchial Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO, OR AS A CONSEQUENCE OF

(b) Bronchogenic Carcinoma — 6 Months

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gove rise to immediate cause (a), stoting the underlying couse lost.

1621

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At hame, form, street, factary, affice building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I taak charge af the remains described above, held an Autapsy [ ], Inspectian [X], Inquiry [X], and in my apinian death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Hamicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED November 8, 1970

ADDRESS(Street, city, town, or county) Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/11/1970	Sunset Memorial Park	Near Cumberland Alleg Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John J. Hafer Hafer Funeral Service, 230 Balto Ave. Cumberland Md.	NOV 12 1970	Vernon R. Randall

VR A15ME (5)
10M - 1/69

1
FOR STATE HEALTH DEPT.

15957

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15985

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First / Middle / Last	Elizabeth H. (Bess) Koch	2a. DATE KNOWN OF DEATH / ESTIMATED (Month, Day, Year)	Nov. 2, 1970	2b. HOUR	7:20a M
3. SEX	Female	4. RACE	White	5. DATE OF BIRTH	Apr. 21, 1881
6. AGE (In years last birthday)	89 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.		2c. DATE PRONOUNCED DEAD (Month, Day, Year)	Nov. 2, 1970
2d. HOUR	8:00 a M				
7a. BIRTHPLACE (State or foreign country)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. COUNTY OF DEATH	Allegany Md.				
10. CITY OR TOWN OF DEATH	Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	220 Arch St.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Housewife
12b. KIND OF BUSINESS OR INDUSTRY	Own Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Md.	13b. COUNTY	Allegany	13c. CITY OR TOWN	Cumberland
13d. INSIDE CITY LIMITS?	YES ☒ NO ☐	13e. STREET AND NUMBER	220 Arch St.		
14. FATHER'S NAME First / Middle / Last	Thomas Jefferson Smith	15. MOTHER'S MAIDEN NAME First / Middle / Last	Mollie Heron		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	No	16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	Mr. Edward W. Koch, Cumberland, Md.-Son

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Occlusion	Sudden
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Sclerosis	----
DUE TO, OR AS A CONSEQUENCE OF (c)		

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?	YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED Nov. 2, 1970

ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
Burial	Nov. 4, 1970	Rose Hill Cemetery	Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR ADDRESS	James F. Scarpelli, Cumberland, Md.	25a. REC'D BY REGISTRAR DATE	NOV 5 1970	25b. REGISTRAR'S SIGNATURE Vernon B. Randall

VR A15ME (5)
10M - 1/69

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

15953

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15986

1. DECEASED-NAME (Type or Print) First	Middle	Last
John	Anderson	Kreiling

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month 11 Day 14 Year 1970 — 2b. HOUR AM 3:30

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN.
Male	White	July 1, 1903	67 YRS.				

2c. DATE PRONOUNCED DEAD Month 11 Day 14 Year 1970 — 2d. HOUR AM 3:30

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Maryland	U.S.A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	522 Riehl Avenue	Retired Pres of Bakery.	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Cumberland	YES [X] NO [ ]	522 Riehl Avenue

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John	Phillip	Kreiling	Julia		Wagner

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	214-05-5167	Mrs. Erma M. Kreiling	522 Riehl Avenue Cumberland, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Sclerosis — --

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X] Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED November 14, 1970

ADDRESS(Street, city, town) Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Nov 17, 1970	Frostburg Memorial Park	Frostburg Allegany Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Silcox-Merritt Funeral Service. Cumberland, Md 21502	NOV 17 1970	Vernon P. Randall

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

1

15959

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
CHARLES	W.	LAING	NOVEMBER 11, 1970	9:30 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	WHITE	5-27-88	82 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
MARYLAND	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	RETIRED-Mail Carrier-Government	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	802 WILLIAMS ST

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
HENRY		LAING	~~ERNA~~ ANNA		GRABENSTEIN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	215-34-4827	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 mo

DUE TO, OR AS A CONSEQUENCE OF

(b) Generalized Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4339

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS / DR CONTRIBUTING / (If either, notify medical examiner) — UNDERLYING CAUSE OF DEATH [ ]	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State
		Cumberland, Allegany, Md.

22a. I **certify** that (I) (this hospital) attended the deceased from 4/5/63, 19____, to 4/11/70, 19____, that (I) (~~we~~) last saw the deceased alive on 4/11/70 19____, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE		22c. DATE SIGNED
R. J. Williams M.D.	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	11/14/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. R.J.WILLIAMS	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Nov.14,1970	St. Mary's Cemetery	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	NOV 17 1970	Vernon R. Randall

VR A15(M)
25m-1-70

1

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
10M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH

15960

15988

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)	First	Middle	Last	2a. DATE KNOWN OF DEATH ESTIMATED	Month	Day	Year	2b. HOUR			
	FRANK	E.	LEAKE	X	Nov.	27,	1970	9:03a M			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.	2c. DATE PRONOUNCED DEAD Month	Day	Year	2d. HOUR
MALE	WHITE	JUNE 4, 1885	85 YRS.					November	27,	1970	9:03a M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH	
MARYLAND	U.S.A.		ALLEGANY	Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL--DOA	LABORER	EXPLOSIVES

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES ☐ NO ☒	WINCHESTER ROAD R.F.D. 5, CUMBERLAND

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JOHN		LEAKE	JANE		HAWTHORNE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO	N.A.	214-05-9634	CUMBERLAND (WINCHESTER ROAD) MD. MRS. EDWARD GRABENSTEIN, R.F.D. 5,

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY SCLEROSIS — ----

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED Nov. 27, 1970

ADDRESS (Street, city, town or county) CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
BURIAL	11/30/70	ST. MICHAEL'S CEM.	FROSTBURG, ALLEGANY, MD.	

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
MARLOU M. SOWERS, HAFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG	DEC 2 1970	Vernon R. Randall	

Marlou M. Sowers

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15961 — 15989

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
ETHEL	M.	LYONS	11 7 70	2:05P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
FEMALE	WHITE	4-30-00	70 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Housekeeper- At Home	

13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	433 COLUMBIA ST.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
CHARLES		BRANT	EFFIE		WOLFORD

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	217-28-9543	MEMORIAL HOSPITAL	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 week

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Terminal arteriosclerotic Heart disease — many years

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	

21a. ACCIDENT WAS OR CONTRIBUTING / UNDERLYING CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from June 7, 19 70, to 11/7, 19 70, that (I) (we) last saw the deceased alive on 11/7 19 70, and that in (my) (aur) apinian death accurred an the date and haur and from the causes stated abave, (I) (we) (did) (did nat) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
B. Schindler MD	MD	[X]	[ ]	[ ]	11/9/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. B. SCHINDLER	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/10/70	Greenmount Cemetery	Cumberland Allegany Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Silcox-Merritt Funeral Service. Cumberland, Md 21502	NOV 12 1970	Vernon G. Randall

VR A15(4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15962

CERTIFICATE OF DEATH

15990

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
COLONEL	ELLSWORTH	MARTENEY	11	3	70	7:25A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.
MALE	WHITE	8-4-95	75 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
W. VA.	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	CAR INSPECTOR	RY. WESTERN MD.

13a. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER
W. VA.	MINERAL	FORT ASHBY		RT. 2 ALONG RT. U.S.# 28

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JEFFS.	--	MARTENEY	IDA	--	STRADER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or Unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
YES	W.W. II	705-10-8404	MRS. PEARL P. MARTENEY RT. #2 KEYSER, W. VA.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary thrombosis	4 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Arteriosclerotic heart disease	yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from January, 1968, to Nov 3, 1970, that (I) (we) last saw the deceased alive on Nov 3 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
B Mitchell Schindler MD	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	11/4/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. B. SCHINDLER	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	11/6/70	HILLCREST BURIAL PARK	CUMBERLAND, ALLEGANY MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. WAYNE GEORGE, CUMBERLAND, MD.	NOV 9 1970	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (Rev.)
45M - 1-69

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funerol director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used os o burial-transit permit. File poges 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15963

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15991

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH ESTIMATED	2b. HOUR
Leo	Henry	Metzner	X Month Day Year: Nov. 5, 1970	6:10 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month Day Year 19	2d. HOUR
Male	White	4/ 9/1906	64 YRS.			November 5, 1970 19	6:10 PM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	U S A	MARRIED (XX)	Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	DOA Sacred Heart Hospital	Retired	C&P RR

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	Cresaptown	YES / NO	Main Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John		Metzner	Margaret		Martz

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	712-14-1633	Mrs. Margaret Bucklew, 18 Roselawn Ave. La Vale, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Coronary Sclerosis

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES / NO (X)

21a. EXTERNAL CAUSE WAS PRIMARY / OR CONTRIBUTING CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection (X), Inquiry (X) and in my opinion death resulted from: Natural causes (XX) Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER (X)

22b. DATE SIGNED NOVEMBER 5, 1970

ADDRESS(Street, city, town) CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/ 9/1970	St. Ambrose Catholic Cem	Cresaptown Alleg Md.

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hafer Funeral Service, 230 Baltimore Ave Cumberland Md	NOV 10 1970	Vernon R. Randall

7 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15964 15992

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
RALPH	ALBERT	MICHAEL	11 4 70	7:20A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
MALE	WHITE	6-23-95	75 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	CUMBERLAND MEMORIAL HOSPITAL	FOREMAN	TEXTILES

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	56 MARION ST.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
WILLIAM	A.	MICHAEL	ADA		MEESE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
YES	WW I	217-10-5579	MEMORIAL HOSPITAL	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4109	IMMEDIATE CAUSE (a) Acute Myocardial Infarct	36 hr
	DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis	
	DUE TO, OR AS A CONSEQUENCE OF (c)	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature]	MD	[X]	[ ]	[ ]	11-7-70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
BRAD. MED. GRP.	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	11/7/70	GREENMOUNT CEMETERY	CUMBERLAND, ALLEGANY, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
HAFER FUNERAL SERVICE	230 BALTIMORE AVENUE CUMBERLAND, MD.	NOV 10 1970	Vernon R. Randall

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15965

CERTIFICATE OF DEATH

15993

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
HAROLD	H	MILLER	11 16 70	5:35 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
MALE	WHITE	1-13-18	52 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	UNITED STATES	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND, MD.	MEMORIAL HOSPITAL		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	FROSTBURG	YES [ ] NO [X]	RT 2, BOX 332

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
DANIEL		MILLER	LILLIAN		BLANK

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
	216-09-6875	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cirrhosis of The Liver, Laurec's — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO, OR AS A CONSEQUENCE OF (b) Type 5710

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	

21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner)	UNDERLYING CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
[ ]	[ ]		

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
[ ] / [ ]					

22a. I certify that (I) (this hospital) attended the deceased from 11/11/70, 19__, to 11/16, 1970, that (I) (we) lost saw the deceased alive on 11/15 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
P.R.S.G. Weisman MD	MD	[ ]	[ ]	[ ]	11/16/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
P.R.S.G. WEISMAN for DR. B. SCHINDLER	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	NOV. 18 '70	FBG. MEMORIAL PARK	FROSTBURG, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST, FROSTBURG, MD.	21532	NOV 23 1970	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(N)
25m-1170

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15966 — 15994

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	MABEL	Middle W.	Last MILLER
2a. DATE OF DEATH Month Day Year	NOVEMBER 20 1970	2b. HOUR	2:15P M
3. SEX	FEMALE		
4. RACE	WHITE		
5. DATE OF BIRTH	2-[illegible]-10		
6. AGE (In years last birthday)	60 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country)	PENNA.		
7b. CITIZEN OF WHAT COUNTRY?	USA		
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]			
9. COUNTY OF DEATH	ALLEGANY Md.		
10. CITY OR TOWN OF DEATH	CUMBERLAND		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	MEMORIAL HOSPITAL		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	HWFE.		
12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	MD.		
13b. COUNTY	ALLEGANY		
13c. CITY OR TOWN	CUMBERLAND		
13d. INSIDE CITY LIMITS?	YES [ ] NO [X]		
13e. STREET AND NUMBER	RT.#3, MASON ROAD		
14. FATHER'S NAME First	JOHN	Middle	Last DICKERHOFF
15. MOTHER'S MAIDEN NAME First	SARAH	Middle	Last MARTZ
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	No		
16b. SOCIAL SECURITY NO.	214-05-6147		
17. INFORMANT Address	MEMORIAL HOSPITAL, CUMBERLAND, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Massive Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO, OR AS A CONSEQUENCE OF

(b) Coronary Occulsion — 5 days

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — I109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS OR CONTRIBUTING [ ] UNDERLYING CAUSE OF DEATH [ ] (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from Oct. , 19 70 to Nov. 20 , 19 70 , that (I) (we) last saw the deceased alive on Nov. 20 1970 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE [signature] DEGREE — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED 11-23-70

22d. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT — 22e. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/23/70	Sunset Memorial Park	Cumberland Allegany Maryland
24. FUNERAL DIRECTOR ADDRESS	Silcox-Merritt Funeral Service. Cumberland, Md 21502	25a. REC'D BY REGISTRAR DATE	NOV 24 1970
25b. REGISTRAR'S SIGNATURE	Vernon R. Randall		

VR A15 (M) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15967 15995

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: FLORA	Middle: CATHERINE	Last: MILLS	2a. DATE OF DEATH Month Day Year: NOVEMBER 26, 1970	2b. HOUR: 10:47 AM
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 06-18-14	6. AGE (In years last birthday): 56 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): WEST VIRGINIA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.): KITCHEN WORK	12b. KIND OF BUSINESS OR INDUSTRY: RESTUARANT		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: RAWLINGS	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: Rt. # 3 Along U. S. Rt. 220	
14. FATHER'S NAME First: JAMES	Middle	Last: KETTERMAN	15. MOTHER'S MAIDEN NAME First: VIRGINIA	Middle	Last: VANMETER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 215-20-5803	17. INFORMANT Address: HOSP. RECORD-900 SETON DRIVE, CUMB. MD.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute coronary occlusion	1/2 hour
DUE TO, OR AS A CONSEQUENCE OF (b)	coronary insufficiency	2 weeks
DUE TO, OR AS A CONSEQUENCE OF (c)	arteriosclerosis	1 year

4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** that (I) (this hospital) attended the deceased from 11-15, 1970, to 11-26-, 1970, that (I) (we) last saw the deceased alive on 11-26 19 70, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: L. Brings	DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 11-26-70	
22d. PHYSICIAN'S NAME (Type): LEWIS BRINGS, M.D.	22e. ADDRESS: 57 GREENE ST., CUMBERLAND, MD. 21502		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 11/29/70	23c. NAME OF CEMETERY OR CREMATORY: Waxler Cemetery	23d. LOCATION (City or Town) (County) (State): Danville, Allegany Md.	
24. FUNERAL DIRECTOR: H. Wayne George	ADDRESS: GEORGE FUNERAL HOME, 202 GREENE ST., CUMB. MD.	25a. REC'D BY REGISTRAR DATE: DEC 1 1970	25b. REGISTRAR'S SIGNATURE: Vernon B. Randall	

VR A15 (4)
45M - 1/69

14

15968

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15996

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
ELDYR	MARY	MOORE	NOVEMBER 19, 1970	7:40AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
FEMALE	WHITE	01-20-99	71 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	REGISTERED NURSE	HOSPITAL

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES [ ] NO [X]	CRESAP DRIVE, BOWLING GREEN

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
THOMAS	J.	Robosson	ANNA		ROBINETTE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	214-07-0710-B	HOSP. RECORD-900 SETON DRIVE, CUMB., MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Congestive Heart Failure	2 wk
DUE TO, OR AS A CONSEQUENCE OF (b)	Lymphoma	1 yr
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Victor E. Mazzocco M.D.		[X]	[ ]	[ ]	11-20-70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
V. EUGENE MAZZOCCO, M.D.	912 SETON DRIVE, CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	NOV 21,1970	HILLCREST BURIAL PARK	CUMBERLAND ALLEGANY MARYLAND

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
SILCOX-MERRITT FUNERAL HOME, CUMB., MD.	NOV 23 1970	James G. Randall

VR A15 (1)
45M - 1/69

FEMALE	WHITE	01-20-23	71
MARYLAND — USA			ALLEGANY
CUMBERLAND	SACRED HEART HOSPITAL	REGISTERED NURSE	HOSPITAL
MARYLAND	ALLEGANY CUMBERLAND	X	CRESAP DRIVE, BOWLING GREEN
TRAINS	EL. ESC	ANNA	ACCIDENTE

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1/69

15969

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item#13e, Film G431 12/18/70 kam

CERTIFICATE OF DEATH

15997

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
HUGH	A.	MULLANEY	11 4 70	6:15 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	WHITE	SEPT. 16, 1915	55 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	USA	NEVER MARRIED [X]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	R.#0. BOX 232 Rural Cumberland Road Willowbrook

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
HENRY		MULLANEY	LORETTA		MALLOY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO		MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral embolism.	2 days.
DUE TO, OR AS A CONSEQUENCE OF (b)	Congestive heart failure. Ischaemic heart disease	1 month
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Iliac artery embolism.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 10/6, 1970, to 11/4, 1970, that (I) (we) last saw the deceased alive on 11/4 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
P. Halmos MD	[ ]	[ ]	[X]	11/7/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. P. HALMOS	122 S. CENTRE ST., CUMB., MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/7/70	St. Patricks Cem.	Mt. Savage Allegany Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Lewis Stein Inc.	Cumb. Md	NOV 10 1970	Vernon C. Randall

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

15970

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15998

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year	2b. HOUR
STATTEN	J	REED	11-20-70 1970	11:58a M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Male	White	7-10-98	72 YRS.			November 20, 1970 19	11:58a M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
W.Va	USA		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Sacred Heart Hospital	Retired	Brewery

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Cumberland	YES [X] NO [ ]	109 Polk St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Thomas		Reed	Carrie		Warnick

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	214-05-4805	Nina Rogan, Philadelphia, Pennsylvania

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Occlusion	Hours
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Sclerosis	---
DUE TO, OR AS A CONSEQUENCE OF (c)		

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED November 20, 1970

ADDRESS (Street, city, town, or county) Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/23/70	Hillcrest Burial Pk.	Cumberland Allegany Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Louis Stein Inc. Cumb. Md	NOV 24 1970	Vernon G. Riddell

VR A15ME 15D
10M REV. 1/68

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15971

15999

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deloy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funerol director. Page 4 should be forworded to the Chief Medical Exominer's Office olong with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to buriol, cremotion, or removol, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First: JOSEPH	Middle: HENRY	Lost: REINHART	2a. DATE KNOWN ☒ OF ESTIMATED ☐ Month Doy Yeor: NOV. 15, 1970
2b. HOUR: 5:05 P.M.	2c. DATE PRONOUNCED DEAD Month Doy Year: Nov. 15, 1970	2d. HOUR: 5:05 P.M.	
3. SEX: MALE	4. RACE: CAU.	5. DATE OF BIRTH: 8/13/1877	6. AGE (In years last birthday): 93 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): LIONS MANOR NURSING HOME	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RETAIL MERCHANT	12b. KIND OF BUSINESS OR INDUSTRY: FURNITURE STOR
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 11 SOUTH LEE ST. CUMB. MD.			
14. FATHER'S NAME First: JOHN	Middle: HENRY	Lost: REINHART	15. MOTHER'S MAIDEN NAME First: LUCINDA Middle: — Lost: DOWNEY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO, (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-42-0431	17. INFORMANT: THOMAS A. REINHART	ADDRESS: 11 SOUTH LEE ST. CUMB. MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), ond (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (o): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

4109

Conditions, if ony, which gave rise to immediate cause (o), stoting the underlying couse lost.

DUE TO, OR AS A CONSEQUENCE OF (b): CORONARY SCLEROSIS — -----

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Doy, Yeor HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: 11/16/70

ADDRESS(Street, city, town, or county): RT. #9 Balto. Pike Cumb. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 11/18/70	23c. NAME OF CEMETERY OR CREMATORY: SS. PETER & PAUL CEMETERY	23d. LOCATION (City or Town) (County) (State): CUMBERLAND, ALLEGANY, MD.	
24. FUNERAL DIRECTOR: H. WAYNE GEORGE	ADDRESS: CUMBERLAND, MD.	25a. REC'D BY REGISTRAR DATE: NOV 19 1970	25b. REGISTRAR'S SIGNATURE: Vernon R. Randall	

VR A15ME (3)
10M - 1/69

1

15972

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper(s). Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: JOHN	Middle: V.	Last: RICHARDSON	2a. DATE OF DEATH Month: 11 Day: 30 Year: 70	2b. HOUR: 5:05 P.M.		
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: OCT. 21, 1897	6. AGE (In years last birthday): 73 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.				
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): MAINTENANCE DEPT.	12b. KIND OF BUSINESS OR INDUSTRY: A&E PLANT				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: FROSTBURG	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 179 MT. PLEASANT ST.			
14. FATHER'S NAME First: JOHN	Middle:	Last: RICHARDSON	15. MOTHER'S MAIDEN NAME First: CHARLOTTE	Middle:	Last: BOWEN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 213-10-9856	17. INFORMANT: MEMORIAL HOSPITAL,	Address: CUMBERLAND, MD.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Multiple Pulmonary Infarctions — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF with Obliterans

(c) Generalized Arteriosclerotic Cardiovascular Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Acute Arterio-obliterans-block or right let.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS / DID CONTRIBUTE / (If either, notify medical examiner)	UNDERLYING CAUSE OF DEATH [ ]	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 1967, 19___, to Nov, 1970, that (I) (~~not~~) last saw the deceased alive on 11-30-70 19___, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~XXXXXX~~ did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED
		12-2-70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. G. O. HIMMELWRIGHT	133 VA. AVE., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR ~~CREMATORY~~	23d. LOCATION (City or Town) (County) (State)
Burial	12/3-1970	Frostburg Memorial Park	Frostburg, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
J. R. Durst, Frostburg, Md 21532	DEC 9 1970	Vernon R. Randall

VR A15-2
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15973

CERTIFICATE OF DEATH

16001

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
BELMONT	MILSON	ROBINETTE	11	26	70	4:25PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
MALE	WHITE	05-31-02	68 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
WEST VIRGINIA	UNITED STATES	WIDOWED [X]	ALLEGANY COUNTY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND, MD.	SACRED HEART	TIRE CONSTRUCTION	TIRE CO.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES / NO	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES [X]	FT. CUMBERLAND HOTEL

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
DENNIS		ROBINETTE	ANN	MARY	MC DONALD

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	214-07-0508	HOSPITAL RECORD, SACRED HEART

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Carcinomatosis, primary	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	Ca bronchogenic carcinoma	6 mth
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from [illegible], 19 66, to 11/26, 19 70, that (I) (we) last saw the deceased alive on [illegible] 19 70, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYS. [ ] MED. DIRECTOR [X] STAFF PHYS. [ ]	11/29/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
S. G. WEISMAN, M.D.	59 GREENE STREET, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/29/70	Sunset Memorial Park	Cumberland, Allegany Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Wayne George GEORGE'S FUNERAL HOME, CUMBERLAND, MD.	202 GREENE STREET	DEC 1 1970	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A(5-2)
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15974 — 16002

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the buriol-transit permit. Then please remove corbon papers. Pages 1 and 2 should be filed with the State Dept. of Heolth prior to buriol, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: WALTER,	Middle: M.	Last: RUBY	2a. DATE OF DEATH Month: 11 Day: 20 Year: 70	2b. HOUR: 2:40 M
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 01 22 09	6. AGE (In years last birthday): 61 XX YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY COUNTY, Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RETIRED CARPENTER	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: PENNSYLVANIA	13b. COUNTY: BEDFORD	13c. CITY OR TOWN: RURAL	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: RT. #3, BOX 450A, CUMB., MD. 21502	
14. FATHER'S NAME First: CHARLES	Middle	Last: RUBY	15. MOTHER'S MAIDEN NAME First: (RUBY) RUTH	Middle: JANE	Last: RUBY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 173-14-4873	17. INFORMANT: SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,	Address: MD. 21502		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO, OR AS A CONSEQUENCE OF (b): Pulmonary Emphysema — 5 years
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 492X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town / County / State

22a. **I certify** that (I) (this haspital) attended the deceased from _____, 19____, ta _____, 19____, that (I) (we) lost saw the deceosed alive an _____ 19____, and that in (my) (aur) opinian death occurred on the dote and hour and from the causes stated obave, (I) (we) (did) (did nat) view the body after deoth.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
V. E. Mazzocco	MD	[X]	[ ]	[ ]	11-20-70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
V. EUGENE MAZZOCCO, M.D.	912 SETON DRIVE, CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/23/70	P.O.S. of A. Cemetery	Centerville, Bedford, Pa.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Charles E. Hafer — HAFER FUNERAL HOME, 230 BALTIMORE AVE., CUMB.	MD. 21502	NOV 24 1970	Vernon R. Randall

VR A15 (4) 45M - 1/69

15578

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15975

16003

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
CARRIE		SHAFFER	11	20	70	12:20A

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
FEMALE	WHITE	11-23-89	80 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
W. VA.	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND,	MEMORIAL HOSPITAL	Housewife,	Own home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES ☐ NO ☒	209 AVE M, POTOMAC PARK

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
WILLIAM	F.	ADAMS	LAURA		ROY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No.	214-07-6618	MEMORIAL HOSPITAL CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pontia, Sept, Acute	14 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Bronchopneumonia	14 days
DUE TO, OR AS A CONSEQUENCE OF (c)	Massive Cerebral Infarction	21 days

4330 Conditians, if any, which gave rise to immediate couse (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hypertension & Arteriosclerosis & Cerebral Arterial Insufficiency - 3yrs

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	Stote

22a. **I certify** that (I) (this hospital) attended the deceased from 1947 to 11/20/, 1970, that (I) (we) last saw the deceased alive on 11/19/1970, and that in (my) (our) opinion death occurred on the date and haur and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Herman M. Weisman		☒	☐	☐	11/20/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. H. M. Weisman DR. ~~P.~~ SCHINDLER	59 GREENE ST. CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (Stote)
Burial	11/22/70	Terra Alta Cemetery,	Terra Alto Preston, W. Va.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Wayne George 202 Greene St. Cumberland, Md.	NOV 24 1970	Vernon O. Randall

VR A15 (4)
45M - 1/69

1

15976

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16004

1. DECEASED-NAME (Type or print) First: Robert Middle: Leroy Lost: Shaw	2a. DATE OF DEATH Month: Nov. Day: 26 Year: 1970	2b. HOUR: 4:15 P.M.	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 02-24-81	6. AGE (In years last birthday): 89 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Sylvan Retreat	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐ 13e. STREET AND NUMBER
14. FATHER'S NAME First: Zedock Middle: Lost: Shaw	15. MOTHER'S MAIDEN NAME First: Elizabeth Middle: Lost: Green		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 232-26-0361-J1	17. INFORMANT: Leslie Shaw Address: Westernport Md	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebro Vascular accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4369

DUE TO, OR AS A CONSEQUENCE OF (b) Gen. arteriosclerosis — yrs

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from Aug. 6, 1969, to Nov. 26 1970, that (I) (we) last saw the deceased alive on Nov. 26 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: George M Simons DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 11/28/70	
22d. PHYSICIAN'S NAME (Type): GEORGE M. SIMONS	22e. ADDRESS: Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 11/29/70	23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill
23d. LOCATION (City or Town) (County) (State): Moscow Mills Alle. Md.		
24. FUNERAL DIRECTOR: C. S. Boal ADDRESS: Westernport, Md.	25a. REC'D BY REGISTRAR DATE: DEC 7 1970	25b. REGISTRAR'S SIGNATURE: Simon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A16 (4)
45M - 1/69

14

15977

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16005

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: CHARLES	Middle: E.	Last: SHEPHERD	2a. DATE OF DEATH: 11 Month 18 Day 70 Year	2b. HOUR: 6:55A M	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: JULY 23, 1886	6. AGE (In years last birthday): 84 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): RAWLINGSMD.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.			
10. CITY OR TOWN OF DEATH: CUMBERLAND, MD.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): MEMORIAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): ENGINEER	12b. KIND OF BUSINESS OR INDUSTRY: RAILROAD			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W. VA.	13b. COUNTY: V	13c. CITY OR TOWN: RIDGELEY	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 10 POTOMAC AVE.,		
14. FATHER'S NAME First: JOHN	Middle	Last: SHEPHERD	15. MOTHER'S MAIDEN NAME First: MARGARET	Middle	Last: CARTER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 220 30 8062	17. INFORMANT: MEMORIAL HOSPITAL- CUMBERLAND, MD. Address				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Artery Disease — Approximate interval between onset and death: 1 week

DUE TO, OR AS A CONSEQUENCE OF (b): Generalized Arteriosclerosis

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING ☐ CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town: Cumberland County: Allegany State: Md.

22a. I certify thot (I) (this hospitol) attended the deceased from 11/18/70, 19____, to 11/18/70 19____, that (I) (we) last saw the deceased alive on 11/17/70 19____, and that in (my) (our) opinion death occurred on the date and haur and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] M.D. DEGREE	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 11/20/70	
22d. PHYSICIAN'S NAME (Type): DR. R. J. WILLIAMS	22e. ADDRESS: 122 S. CENTRE ST. CUMBERLAND, MD.		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: NOV. 20, 1970	23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY	23d. LOCATION (City or Town): CUMBERLAND	(County) (State): MD.
24. FUNERAL DIRECTOR: BYRON KIGHT	ADDRESS: CUMBERLAND, MD.	25a. REC'D BY REGISTRAR DATE: NOV 23 1970	25b. REGISTRAR'S SIGNATURE: Vernon R. Randall	

VR A 5 (4) 25m (1/70)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15978 — 16006

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: WILLIAM	Middle: THOMAS	Last: SHIPPER	2a. DATE OF DEATH Month: 11 Day: 24 Year: 70	2b. HOUR: 7:30 P.M.
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 10-18-02	6. AGE (In years last birthday): 68 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [XX] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): MEMORIAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): LAUNDRY DEPT.	12b. KIND OF BUSINESS OR INDUSTRY: HOSPITAL		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 339 CITY VIEW TERRACE	
14. FATHER'S NAME First: GEORGE	Middle	Last: SHIPPER	15. MOTHER'S MAIDEN NAME First: CARRIE	Middle	Last: RICKER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 217-10-7341	17. INFORMANT: Mrs. Virginia Duckworth	Address: 339 City View	
			MEMORIAL HOSPITAL, CUMBERLAND, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): BRONKHOPNEUMONIA RIGHT LUNG — Approximate interval between onset and death: 3 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 492X

DUE TO, OR AS A CONSEQUENCE OF (b): EMPHYSEMA, PULMONARY, SEVERE — 15 years

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Hypertrophy Right Ventricle due to above; "old" Posterior Inferoapical INFARCT

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21a. ACCIDENT WAS OR CONTRIBUTING [ ] UNDERLYING CAUSE OF DEATH [ ] (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19 54, to 11/24, 19 70, that (I) (we) last saw the deceased alive on 11/24 19 70, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] MD DEGREE	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 11/25/70	
22d. PHYSICIAN'S NAME (Type): DR. S. G. WEISMAN	22e. ADDRESS: 54 Greene St Cumberland, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 11/27/70	23c. NAME OF CEMETERY OR CREMATORY: RESTLAWN MEMORIAL GARDENS	23d. LOCATION (City or Town) (County) (State): LAVALE, ALLEGANY, MD.	
24. FUNERAL DIRECTOR: H. WAYNE GEORGE	ADDRESS: CUMBERLAND, MD.	25a. REC'D BY REGISTRAR DATE: DEC 1 1970	25b. REGISTRAR'S SIGNATURE: Vernon R. Randall	

VR A15(4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15979

16007

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Lost	2a. DATE OF DEATH Month Day Year	2b. HOUR
MARGARET	P.	SHUCK	11 06 70	12:35A

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	WHITE	2-10-94	76 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Clerk	Dept. Store

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES ☒ NO ☐	417 Arch St Cumberland

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
AMER	W.	SHUCK	Ella	S.	Bittner

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
N		214-05-8927	MEMORIAL HOSPITAL	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bilateral Pneumonia — 4-91X

DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Bronchitis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic Brain Syndrome due to Arteriosclerotic Cardiovascular Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING CAUSE ☐ OR CONTRIBUTING ☐	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 11/1/70, 19____, to 11/6/70, 19____, that (I) (we) last saw the deceased alive on 11/6/70 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
William P. James for	MD	☒	☐	☐	11/8/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. WILLIAM P. IAMES	441 N CENTRE ST, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11-8-1970	Rose Hill Cemetery	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	NOV 10 1970	Vernon B. Randall

VR A15 (4)
25m-1/70

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15980

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16008

1. DECEASED-NAME (Type or Print) First	Middle	Last
PAUL	LANGFORD	SIMMONS

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month Day Year: 11-6-70 19 — 2b. HOUR: 5:30 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN.
MALE	WHITE	2-9-13	57 YRS.				

2c. DATE PRONOUNCED DEAD: Month November Day 6, Year 1970 19 — 2d. HOUR: 5:30 PM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. COUNTY OF DEATH
TENNESSEE	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
FROSTBURG	MINERS HOSPITAL	RETIRED STAFF SGT.	USAF

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	GARRETT	RFD #1	YES [ ] NO [X]	Rt. 219, BOX 128C

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
AARON		SIMMONS	BETTY	LOU	WILBANKS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	1948-1961	421-14-6526	MRS. MARY SIMMONS	SALISBURY, PA.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4-109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Occlusion	Sudden
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Sclerosis	--
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
ADDRESS (Street, city, town): CUMBERLAND, MARYLAND

22b. DATE SIGNED: NOVEMBER 6, 1970

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	11-9-70	RESTLAWN MEMORIAL PARK	LAVALE ALLEGANY MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST SR.	FROSTBURG, MD.	NOV 10 1970	Vernon P. Randall

VR A15ME (5)
10M REV. 1/68

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15981

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16009

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use os the buriol-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to buriol, cremation, or removol, and in any event, within 72 hours after death.

VR A15-4
30M REV. 7-68

1. DECEASED-NAME (Type or print)	First: Reita	Middle: Thelma	Last: Slaven	2a. DATE OF DEATH: Month Nov. Day 18, Year 70 — 2b. HOUR: 12:50 A.M.
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Oct. 3, 1896	6. AGE (In years last birthday): 74 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN	
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.	
10. CITY OR TOWN OF DEATH: Cumberland,	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 622 Fairview Ave.,	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife,	12b. KIND OF BUSINESS OR INDUSTRY: Own home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland,	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 622 Fairview Ave.,
14. FATHER'S NAME First: John	Middle: E.	Last: Everstine	15. MOTHER'S MAIDEN NAME First: Nellie	Middle: R. Last: Jordan
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No, (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: None	17. INFORMANT: Miss Ruth L. Slaven	Address: 622 Fairview Ave. Cumb. Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Terminal Carcinomatosis, generalized 8 months

DUE TO, OR AS A CONSEQUENCE OF (b): adenocarcinoma, pleuris, probably ovary 8 month.

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1830

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: 24 aug. 70	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Biopsy for above.	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I **certify** that (I) (this haspital) attended the deceased from _____, 19 46, to 18 nov., 19 70, that (I) ~~(we)~~ last saw the deceased alive an 17 nov. 19 70, and that in (my) (our) apinion death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE: W. Alfred Van Ormer	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 19 Nov. 70	
22d. PHYSICIAN'S NAME (Type): W. Alfred VanOrmer, M. D.	22e. ADDRESS: 122 So. Centre St. Cumberland, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 11/20/70	23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park,	23d. LOCATION (City or Town): Cumberland,	(County): Allegany (State): Md.
24. FUNERAL DIRECTOR: H. Wayne George	ADDRESS: 202 Greene St. Cumberland, Md.	25a. RECD BY REGISTRAR DATE: NOV 20 1970	25b. REGISTRAR'S SIGNATURE: Vernon O. Randall	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15982

16010

1. DECEASED-NAME (Type or print) First: ALECK	Middle:	Last: SLOAN	2a. DATE OF DEATH: 11 Month 29 Day 1970
2b. HOUR: M			

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last Birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Male	White	7/15/1878	92 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
MD.	USA.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Lonaconing	Kyle Nurseing Home	Retired Banker	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	Allegany	Lonaconing	YES ☒ NO ☐	Jackson Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
David		Sloan	Margaret		Percey

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	214-12-3147	Kyle Nurseing Home, Lonaconing, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Myocardial ischemia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: weeks

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis — years

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19 56, to Nov. 29, 19 70, that (I) (we) last saw the deceased alive on 11-25 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature] MD		☒	☐	☐	11.30.70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
L.R. MILES, JR	LONACONING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	12/1/1970	Porters Cemetery	Eckhart, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
George Eichhorn	Lonaconing, Md.	DEC 2 1970	Vernon R. Randall

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15983

16011

Item#13c,e,FilmG431 12/18/70 kam

1. DECEASED-NAME (Type or print)	First: KATHERINE	Middle: S.	Last: SMITH	2a. DATE OF DEATH Month: 11 Day: 30 Year: 70	2b. HOUR: 10:20A
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 8-14-~~02~~ 91	6. AGE (In years last birthday): ~~72~~ 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): ~~West Virginia~~	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: ~~Flintstone~~ CUMBERLAND	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: R.F.D. ~~Allg. Co. Infirmary~~	
14. FATHER'S NAME First: Oliver	Middle: Wellington	Last: Schaeffer	15. MOTHER'S MAIDEN NAME First: Kate	Middle: Lupton	Last:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 218-50-0061A	17. INFORMANT: MEMORIAL HOSPITAL	Address: CUMBERLAND, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 days.

DUE TO, OR AS A CONSEQUENCE OF: —

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Old age.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING ☐ CAUSE OF DEATH / DR CONTRIBUTING ☐	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 11/ , 19 70, to 11/30, 19 70, that (I) (we) last saw the deceased alive on 11/29 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature]	MD	☐	☐	☑	12/1/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. HALMOS	LA VALE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	12/2/70	Indian Mound Cemetery	Romney, Mineral, W. Va.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Philip B. Wendt 121 Memorial Ave., Cumb., Md.	DEC 4 1970	Vernon B. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15984 16012

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
WILLIAM	ALLAN	SMITH	11 19 70	4:30 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
MALE	WHITE	12-24-00	69 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
W. VA.	UNITED STATES	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY, Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND,	SACRED HEART HOSPITAL	RETIRED KENNEWEG WHOLESALE COMPANY	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	520 BEALL STREET

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
RUFUS	A.	SMITH	NETTIE	GRACE	BROWNING

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	232-07-7636	HOSPITAL RECORD, 900 SETON DR. CUMBERLAND, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma, left lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Uncertain
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 11-11, 1970, to 11-19, 1970, that (I) (we) last saw the deceased alive on 11-19 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Calvin Y. Hadidian	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	11/20/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
C.Y. HADIDIAN, M. D.	203 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	NOV 21 1970	HAMILL CEMETERY	KITZMILLER GARRETT MARYLAND

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
SILCOX MERRITT FUNERAL HOME, 404 DECATUR ST. CUMBERLAND, MD.	NOV 23 1970	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 11 69

X

Item#5 & Item#6, Film G431 12/15/70 kam

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16013

15985

1. DECEASED NAME (Type or Print) First: Harry Middle: Snyder Last:
2a. DATE OF DEATH Month: NOV Day: 30 Year: 1970
2b. HOUR: 7:05 AM
3. SEX: M
4. RACE: W
5. DATE OF BIRTH: 10-2-1885
6. AGE (In years last birthday): 85 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN
7a. BIRTHPLACE (State or foreign country): Barton Md.
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: Allegheny Md.
10. CITY OR TOWN OF DEATH: Cumb. Md
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Cumb. Nursing Center
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.
13b. COUNTY: Allegany
13c. CITY OR TOWN: Barton
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER
14. FATHER'S NAME First: Martin Middle: Snyder Last:
15. MOTHER'S MAIDEN NAME First: Charlotte Middle: Last: Green
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 212-03-5991 ANB
17. INFORMANT: Hamil Snyder Address: Barton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertropic Prostate
DUE TO, OR AS A CONSEQUENCE OF
(b): C V A
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4369
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Old age.

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☑
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 11/17, 1970, to 11/30, 1970, that (I) (we) last saw the deceased alive on 11/28 19 70, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: P B Fulmer MD DEGREE
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 12/1/70
22d. PHYSICIAN'S NAME (Type): P. B. HALMOS
22e. ADDRESS: Memorial Hosp. Cumberland.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 12/2/70
23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill
23d. LOCATION (City or Town) Moscow Mills-Alle. (County) Md (State)
24. FUNERAL DIRECTOR: Boods Funeral Home
ADDRESS: Westernport
25a. REC'D BY REGISTRAR DATE: DEC 7 1970
25b. REGISTRAR'S SIGNATURE: Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Books 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15986 — 16014

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
EUGENE	GEORGE	STEESE	11-	17	70	8:50 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
MALE	WHITE	1-16-1904	66 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. COUNTY OF DEATH
OHIO	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	RETIRED Bus Driver	Transportatio

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES ☐ NO ☒	BEL AIR 114 SHAMROCK RD.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
GEORGE		STEESE	EMMA		BAILETT

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No,	287-01-1655	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Infarctions of the brain, multiple — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 YRS

4330 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Thromboses — 3 YRS

DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis + Hypertension — 4 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Hypertension + Arteriosclerotic Ht. Disease Treated Live

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from ____, 1966, to 11/17, 1970, that (I) (we) last saw the deceased alive on 11/17 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
S. G. Weisman MD		☒	☐	☐	11/18/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. S. G. WEISMAN	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/20/70	St. Mary's Cemetery	Cumberland, Allegany Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Wayne George Cumberland, Maryland	NOV 20 1970	Vernon G. Randall

VR A15 (M) 25m-1,70

Item 22a Film 431 12/30/7

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15987 16015

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
GRACE	G.	STEINER	11 30 70	2:00PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
FEMALE	WHITE	06-26-82	88 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	UNITED STATES		ALLEGANY, Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	Retired Executive Secy-	Deaconess.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES ☒ NO ☐	107 S. LEE ST.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JOHN	W.	STEINER	ALICE		MALONE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	133-26-3160	HOSPITAL RECORD, 900 SETON DR. CUMB. MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Probable Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF (b) Possible Pulmonary Embolism

DUE TO, OR AS A CONSEQUENCE OF (c) (R) Hip Fracture

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, natify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this haspital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Natural Causes

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Jack W. Harvey M.D.	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐	

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
HARVEY, JACK W., M.D.	500 GREENE ST., CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	12/3/70	RoseHill Cemetery	Cumberland Allegany Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
SILCOX-MERRITT FUNERAL SER.,	404 DECATUR ST. CUMBERLAND, MD	DEC 4 1970	Vernon O. Randall Jr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

15988

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16016

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: DANIEL	Middle: VERNON	Last: STUFFT	2a. DATE OF DEATH Month: 11 Day: 16 Year: 70	2b. HOUR: M	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 1/10/15	6. AGE (In years last birthday): 55 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): PENNA.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 126 ~~XXXXXXX~~ ELDER ST.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Groceryman	12b. KIND OF BUSINESS OR INDUSTRY: Own Grocery			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 126 ELDER STREET		
14. FATHER'S NAME First: James	Middle: B. W.	Last: Stufft	15. MOTHER'S MAIDEN NAME First: Edith	Middle: Risinger	Last:	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes War II (If yes give war or dates of service): War II	16b. SOCIAL SECURITY NO.	17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction, antero-lateral wall ~~heart~~ heart failure
DUE TO, OR AS A CONSEQUENCE OF (b): Ischemic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: (a) 16 Nov. 70 (instant death) (b) ?

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Aortic stenosis with aortic valve replacement 5 years ago.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. I certify that (I) (this hospital) attended the deceased from Nov. 1965, to 16 Nov. 1970, that (I) ~~(we)~~ last saw the deceased alive on 15 Oct. 1970, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE: W. Alfred Van Ormer	DEGREE	ATTENDING PHYS. [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]	22c. DATE SIGNED: 19 Nov. 70	
22d. PHYSICIAN'S NAME (Type): DR. W. A. VAN ORMER	22e. ADDRESS: Cumberland, Md.					

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Nov. 19, 1970	23c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery	23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md	
24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: NOV 20 1970	25b. REGISTRAR'S SIGNATURE: Vernon R. Randall		

VR A15(M) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15989

16017

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
MAE	G.	TAYLOR	11	26	70	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
FEMALE	WHITE	1-15-1900	70 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MD.	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
FROSTBURG	252 E. MAIN ST.	SECRETARY	INSURANCE

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	FROSTBURG	YES [X] NO [ ]	252 E. MAIN STREET

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
PHILLIP		GERLACH	STELLA		TILEY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	213-10-9696	PAUL V. TAYLOR 252 E. MAIN, FROSTBURG, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction - massive — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
NONE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
✓	✓	YES [ ] NO [X]	✓

21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner)	UNDERLYING CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
[ ]	[ ]	✓	✓

21d. INJURY OCCURRED While at work	Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
[ ]	[ ]	✓	✓			

22a. **I certify** that (I) (this hospital) attended the deceased from 11-5, 1970, to 11-26, 1970, that (I) (we) last saw the deceased alive on 11-23 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Martin M. Rothstein		[X]	[ ]	[ ]	11-27-70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
MARTIN M. ROTHSTEIN M.D.	48 BROADWAY, FROSTBURG, MD. 21532

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	11-28-70	FROSTBURG MEMORIAL PARK	FROSTBURG, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST SR. FROSTBURG, MD.	DEC 2 1970	Vernon R. Randall

VR A15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15990

16018

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First MARY; Middle Josephine; Last THOMPSON

2a. DATE OF DEATH: 11 Month 23 Doy 70 or

2b. HOUR: 9:00 PM

3. SEX: FEMALE

4. RACE: WHITE

5. DATE OF BIRTH: 12 24 99

6. AGE (In years last birthday): 70 YRS. IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (State or foreign country): MARYLAND

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. COUNTY OF DEATH: ALLEGANY Md.

10. CITY OR TOWN OF DEATH: CUMBERLAND, MD.

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): SACRED HEART HOSPITAL

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): KELLY SPRINGFIELD TIRE CO.

12b. KIND OF BUSINESS OR INDUSTRY:

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND

13b. COUNTY: ALLEGANY

13c. CITY OR TOWN: CUMBERLAND

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET AND NUMBER: 814 EDGEWOOD DRIVE

14. FATHER'S NAME: First JAMES; Middle J.; Last THOMPSON

15. MOTHER'S MAIDEN NAME: First (MC CAUGHAN) ELIZABETH; Middle; Last THOMPSON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.: 212 24 1030

17. INFORMANT: PATIENT'S CHART 900 SETON DRIVE CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Adeno-carcinoma of sigmoid — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 mos

1533

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Year 19

21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. **I certify** that (I) (this haspital) attended the deceased from 8 - 9, 19 62, to 11 - 23, 19 70, that (I) (we) last saw the deceased alive an 11 - 23 19 70, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did not) view the bady after death.

22b. SIGNATURE: R.W. Ballin M.D. DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. DATE SIGNED: 11-24-70

22d. PHYSICIAN'S NAME (Type): R.W. BALLIN, M.D., 51 GREENE ST,

22e. ADDRESS: CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 11/26/70

23c. NAME OF CEMETERY OR CREMATORY: St. Michaels Catholic Cemt.

23d. LOCATION (City or Town) (County) (State): Frostburg Allegany Md.

24. FUNERAL DIRECTOR ADDRESS: SILCOX, MERRITT, 404 DECATUR ST, CUMB., MD.

25a. REC'D BY REGISTRAR DATE: NOV 30 1970

25b. REGISTRAR'S SIGNATURE: Vernon R. Randall

VR A15 (4) 45M - 1/69

11 - 23 70

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15991

16019

FOR STATE HEALTH DEPT.

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month Day Year	2b. HOUR
William	E.	Timney	Nov. 13, 1970	6p M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Male	White	3/21/1914	56 YRS.					November 13, 1970	6:20p

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
MD.	USA		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital--DOA	Celanese Corp.	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	Allegany	Lonavoning	YES ☒ NO ☐	Jackson Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Alex		Timney	Clara		WARNICK

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		Mrs. Lois Shockey, Lonaconing, Md. (DAUGHTER)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hemothorax — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO, OR AS A CONSEQUENCE OF (b) Crushed Chest — "

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

8190

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
	6 pm 11-13-70	Driver in one Car Accident

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State
	Rt.# 40	Overhead Bridge, Cumberland, Alleg. Md.

22a. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED November 13, 1970

ADDRESS (Street, city, town) CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/16/1970	Sunset Memorial Park	Cumberland, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
George Eichhorn Lonaconing, Md.	NOV 17 1970	Vernon R. Randall

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 10M - 1/69

15391

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15992

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16020

1. DECEASED-NAME (Type or Print) First	Middle	Last
David	Marcellus	Togans

2a. DATE KNOWN OF DEATH ESTIMATED: X — Month Day Year: 11-4-70 19 — 2b. HOUR: 11a M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS: HOURS	MIN.
Male	Negro X	Nov. 25, 1918	51 YRS.				

2c. DATE PRONOUNCED DEAD: Month Novermer Day 4, Year 1970 19 — 2d. HOUR: 11a M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED XX / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	U S A		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Frostburg	Miner's Hospital--DOA	Laborer	B&O RR

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES X NO	13e. STREET AND NUMBER
Maryland	Allegany	Frostburg		158 W. Mechanic Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Alfred		Togans	Eloise		Frazier

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	220-03-7792	Mrs. Garnell Stamper 156 West Mechanic St Frostburg, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

4100

IMMEDIATE CAUSE (a) Coronary Occlusion , left — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Thrombosis, left — "

DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Sclerosis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

CARDIAC HYPERTROPHY (HYPERTENSIVE DISEASE)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES X NO

21a. EXTERNAL CAUSE WAS PRIMARY / OR CONTRIBUTING CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy X Inspection X Inquiry X and in my opinion death resulted from: Natural causes X, Accident , Suicide , Homicide , Undetermined manner

ACTUAL SIGNATURE B. Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic, M.D

CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / DEPUTY MEDICAL EXAMINER XX

22b. DATE SIGNED: Nov. 4, 1970

ADDRESS (Street, city, town) CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/7/70	Frostburg Memorial Park	Frostburg Alleg Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John S. Hafer	Hafer Funeral Service, 230 Balto Ave. Cumberland Md	NOV 10 1970	Vernon R. Randall

VR A15ME (5)
10M REV. 1/68

1
FOR STATE HEALTH DEPT.

15993

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16021

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. (Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)	First: Mary	Middle: Elizabeth (Lee)	Last: Walker	2a. DATE KNOWN OF DEATH [X] ESTIMATED [ ]	Month: 11	Day: 15	Year: 1970	2b. HOUR: 4:30 AM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Sept 16, 1877	6. AGE (In years last birthday): 93 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c. DATE PRONOUNCED DEAD: Month 11	Day 15	Year 1970	2d. HOUR: 4:30 AM
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md.						
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 216 Davidson Street	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housekeeper - At Home	12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 216 Davidson Street					
14. FATHER'S NAME: First David	Middle	Last: Walker	15. MOTHER'S MAIDEN NAME: First Lucy	Middle	Last: Litzenberg				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-05-6312	17. INFORMANT: Miss Cora M. Walker	ADDRESS: 216 Davidson St Cumberland, Md						

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

4319

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

IMMEDIATE CAUSE (a): Cerebral Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO, OR AS A CONSEQUENCE OF

(b): Arteriosclerotic Vascular Disease — ---

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]
21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic, M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: November 15, 1970

ADDRESS (Street, city, town, or county): Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Nov 18, 1970	23c. NAME OF CEMETERY OR CREMATORY: RoseHill Cemetery	23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR: Silcox-Merritt Funeral Service.	ADDRESS: 21502 Cumberland, Md	25a. REC'D BY REGISTRAR DATE: NOV 18 1970	25b. REGISTRAR'S SIGNATURE: Vernon B. Randall	

VR A15ME (3)
10M - 1/69

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15994

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16022

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1. DECEASED-NAME (Type or print) First	CLARENCE	Middle HARLEY	Last WEES
2a. DATE OF DEATH Month 11 Day 29 Year 70	2b. HOUR 12:30 PM		
3. SEX	MALE		
4. RACE	WHITE		
5. DATE OF BIRTH	05-30-92		
6. AGE (In years last birthday)	78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country)	WEST VIRGINIA		
7b. CITIZEN OF WHAT COUNTRY?	USA		
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐			
9. COUNTY OF DEATH	ALLEGANY Md.		
10. CITY OR TOWN OF DEATH	CUMBERLAND		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	SACRED HEART HOSPITAL		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	RETIRED Salesman		
12b. KIND OF BUSINESS OR INDUSTRY	NONE		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	MARYLAND		
13b. COUNTY	ALLEGANY		
13c. CITY OR TOWN	LA VALE		
13d. INSIDE CITY LIMITS? YES ☒ NO ☐			
13e. STREET AND NUMBER	1064 NATIONAL HWY.,		
14. FATHER'S NAME First	MORGAN	Middle L.	Last WEES
15. MOTHER'S MAIDEN NAME First	GEORGIA	Middle	Last WEES
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)	NO	(If yes give war or dates of service)	
16b. SOCIAL SECURITY NO.			
17. INFORMANT Address	HOSP.REC.,900 SETON DR., CUMB., MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac decompensation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 years

5192

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Chronic pulmonary + liver disease — 10 years

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Fracture l/r femur

19a. DATE OF OPERATION	11/17/70	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	Fracture hip
20a. AUTOPSY? YES ☐ NO ☒		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year	11 16 1970
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	Fall at home		
21d. INJURY OCCURRED While at work ☐ Not while at work ☒		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	Home
21f. LOCATION Street or R.F.D. No. / City or Town / County / State			

22a. **I certify** that (I) (this hospital) attended the deceased from 11/26/70, 19 20, to 11/29/70, 19 70, that (I) (we) last saw the deceased alive on 11/29/70 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Robert Feddis	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED 11/30/70
22d. PHYSICIAN'S NAME (Type)	ROBERT FEDDIS M.D.	22e. ADDRESS	500 GREENE ST, CUMB., MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	Burial	23b. DATE	12/2/70	23c. NAME OF CEMETERY OR CREMATORY	St. Peter + Paul Cem.
23d. LOCATION (City or Town) (County) (State)	Cumberland Allegany Md				
24. FUNERAL DIRECTOR	STEINS FUNERAL HOME	ADDRESS	Cumberland Md.	25a. REC'D BY REGISTRAR DATE	DEC 7 1970
25b. REGISTRAR'S SIGNATURE	Vernon R. Randall				

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15995

CERTIFICATE OF DEATH

16023 P.m.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Lola	E	Weisenborn	Nov.	24	70	2:25 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	White	6-9-88	82 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Eckhart, Md.	America	WIDOWED X	Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland, Md.	Lions Manor Nursing Hm.	Housewife	None

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES / NO	13e. STREET AND NUMBER
Maryland	Allegany	Eckhart		

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
LINCOLN		PORTER	LYDA		BENNETT

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
	213-09-6551	Office records, Lions Man. Nur. Hm.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebrovascular Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 30 min

4370

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Vascular ds — 10 yrs

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Hypertension Prior CVA

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature]				☒	11-24-70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
[illegible]	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	NOV. 27 '70	ECKHART CEMETERY	ECKHART MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST, FROSTBURG, MD. 21532	DEC 2 1970	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
30M REV. 1/68

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15996

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16024

1. DECEASED-NAME (Type or print) First: JAMES Middle: B. Last: Williams	2a. DATE OF DEATH Month: 11 Day: 17 Year: 70	2b. HOUR: 9:40 PM	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 01/05/00	6. AGE (In years last birthday): 70 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Cumberland, Nursing Center	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Consultant	12b. KIND OF BUSINESS OR INDUSTRY: Stock Exc.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: Y.M.C.A. Baltimore Ave.			
14. FATHER'S NAME First: James Middle: B. Last: Williams	15. MOTHER'S MAIDEN NAME First: Adelle Middle: Last: Knipper		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: Yes (If yes give war or dates of service): War I	16b. SOCIAL SECURITY NO.: 091-03-9435A	17. INFORMANT: Sister-In-Law Address: Mrs. Paul Williams, Cumberland, Md.	

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MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Adeno-Carcinoma of esophagus	10 mos
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

150X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

ACVD

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. City or Town County State	

2

22a. **I certify** that (I) (this hospital) attended the deceased from 5 - 10, 1970, to 11 - 17, 1970, that (I) (we) last saw the deceased alive on 11-15-70 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Ralph W. Ballin M.D. DEGREE	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 11-18-70
22d. PHYSICIAN'S NAME (Type): Ralph W. Ballin, M.D.	22e. ADDRESS: 51 Greene St. Cumberland, Md. 21502	

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Nov.20,1970	23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR: James F. Scarpelli, Cumberland, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE: NOV 20 1970	25b. REGISTRAR'S SIGNATURE: Vernon B. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

7 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15997

16025

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: JOHN	Middle: THOMAS	Last: WRIGHT	2a. DATE OF DEATH Month: 11 Day: 02 Year: 70 — 2b. HOUR: A 1:25 M
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 11 04 00	6. AGE (In years last birthday): 69 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY COUNTY, Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): RETIRED - KELLY SPRINGFIELD TIRE CO	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: ECKHART	13d. INSIDE CITY LIMITS? YES [ ] NO [ ] — 13e. STREET AND NUMBER: ECKHART, MARYLAND 21528
14. FATHER'S NAME First: WILL	Middle:	Last: WRIGHT	15. MOTHER'S MAIDEN NAME First: (BEEMAN) SUSAN — Middle: ANNA — Last: WRIGHT
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-01-6742	17. INFORMANT: SACRED HEART HOSPITAL, 900 SETON DR., CUMB., Address MD. 21502	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Small cell carcinoma of the lung. 1621

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Coronary artery disease & old Myocardial Infarction

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: C. J. Vincent M.D. — DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]			22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type): C. VINCENT, M.D.		22e. ADDRESS: 924 SETON DR., CUMB., MD. 21502	

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 11/4/70	23c. NAME OF CEMETERY OR CREMATORY: ECKHART CEMETERY	23d. LOCATION (City or Town): ECKHART, MD.	(County) (State)
24. FUNERAL DIRECTOR: DURST FUNERAL HOME, 57 FROST AVE., FROST., MD.	ADDRESS: 21532	25a. RECD BY REGISTRAR DATE: NOV 5 1970	25b. REGISTRAR'S SIGNATURE: Vernon G. Randall	

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15998

16026

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First: HARRY EDWIN	Middle:	Last: YOUNG SR.	2a. DATE KNOWN OF DEATH ESTIMATED ☐ Month: 11 Day: 5 Year: 70	2b. HOUR: 12:30PM	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 2/17/1913	6. AGE (In years last birthday): 57 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month: November Day: 5, Year: 1970	2d. HOUR: 12:30PM
7a. BIRTHPLACE (State or foreign country): KITZMILLER MD.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND MD.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Sacred Heart Hospital-DOA	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): TOOL MAKER	12b. KIND OF BUSINESS OR INDUSTRY: ALLEGANY B.L.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 1428 CHURCH ST.	
14. FATHER'S NAME First: CHARLES	Middle: W.	Last: YOUNG	15. MOTHER'S MAIDEN NAME First: ANNIE	Middle:	Last: STRAHAN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 579-36-7777	17. INFORMANT ADDRESS: Mrs Harry E. Young Sr. Cumberland Md. 21502			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
(b): Coronary Sclerosis — ——
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22b. DATE SIGNED: November 5, 1970
ADDRESS (Street, city, town): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 11/9/70	23c. NAME OF CEMETERY OR CREMATORY: Sunset Memo. & Park	23d. LOCATION (City or Town) (County) (State): Cumberland Md. (Allegany)	
24. FUNERAL DIRECTOR: LOUIS STEIN INC.	ADDRESS: CUMBERLAND MD.	25a. REC'D BY REGISTRAR DATE: NOV 10 1970	25b. REGISTRAR'S SIGNATURE: Vernon R. Randall	

VR A15ME (5)
10M REV. 1/68